THE ATTENDANT'S COMPANION

CHARLES MERCIER, M.B.

A MANUAL OF THE DUTIES OF ATTENDANTS IN LUNATIC ASYLUMS

2/-

Second Edition

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OF THE DUTIES OF

ATTENDANTS IN LUNATIC ASYLUMS

BY

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PREFACE TO SECOND EDITION.

To the request in the closing sentence of the preface to the first edition, only two suggestions of importance have been received. The first is that the book should include an account of such portions of the sciences of anatomy and physiology as it is desirable that an attendant on the insane should know. With this suggestion I have not seen my way to comply. There are several nursing manuals in which such information is given. The handbook published by the Medico-Psychological Association goes into the matter with sufficient fulness. Inclusion of such material would have added to the bulk of the book to a degree out of proportion to its usefulness, and would have impaired the character, that I desired to attach to it, of being essentially and before all things practical. It was intended rather to supplement than to displace more ambitious treatises, and to put before attendants in a homely way subjects that were rather beneath the notice

of other manuals, and that yet appeared important enough to warrant description.

The other criticism is a very curious one. I have been told—and I may say at once that there really seems to be no doubt about the fact—that the publication of the illustrative cases, accompanied by the particulars of the time and place of their occurrence, has given offence. Now, it is unquestionable that an author is bound to avoid hurting the feelings of any of his readers, unless the trumpet-call of some great principle demands that he smite and spare not; and there is no pretence that any such principle is involved in this matter. But, on the other hand, it is not reasonable to expect an author to foresee the existence of such a degree of moral hyperæsthesia as the criticism discovers. A man is bound to avoid inflicting physical injury and pain upon others. But, if in walking along a crowded street, he brushes against some unfortunate being to whom a mere touch is agony, he is not responsible for the pain that he inflicts.

FLOWER HOUSE, CATFORD, S.E.,
1898.

PREFACE TO FIRST EDITION.

SEVERAL handbooks for attendants on the insane are already in existence, and therefore some sufficient reason is needed for adding another. The reason which appeared sufficient to the author of this manual is that, while some of the previous handbooks include subjects which are of doubtful value to attendants, none of them explain their duties with the minuteness, fulness, and precision which appear to him advisable. It is of little use telling an attendant that he is to do a thing, unless it is explained precisely how the thing is to be done. It is of little use to tell him to do a thing sufficiently often or at proper intervals, unless it is explained precisely how many times an hour or a day the thing is to be done, and how many minutes or hours may elapse between each doing. In this manual great care has been taken to leave no uncertainty in the mind of the attendant as to the nature of

his duty, and to traverse the whole field of his duties and leave none unexplained. Wherever it is possible to do so, the importance of a regulation has been emphasised and impressed on the mind of the reader by the record of an actual case in which disastrous consequences have followed the neglect of it.

While hoping that but few omissions or errors will be found in the book, the author, bearing in mind Dr. Johnson's saying that "a fallible being will fail somewhere," will be grateful if his readers will communicate to him any defects that they find, or any additions that they think can be usefully made to it.

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1892.

CONTENTS.

INTRODUCTION.

ATTENDANTS are in actual direct contact with the patients during the whole of their working hours, and are continually subject, during those hours, to the anxieties of their position, which, to a conscientious person, are very great; as well as to the turmoil of the wards, the whims and humours, the objectionable conduct, the foul habits, often the exasperating insults, and even the actual violence of the patients under their care. Their duties are of the most responsible character, it being always possible that a very brief lapse of vigilance or attention may result in a terrible catastrophe—in injury or death to those under their care, and in disaster to their own career. It is therefore most highly desirable that attendants should be clearly instructed in their duties, should know exactly what is expected of them, and should have the best advice as to the way in which their duties should be performed. So arduous and so

anxious are the duties of attendants, and so much self-control do they require, that no one should undertake them who is not of a patient and painstaking disposition, nor should anyone be appointed to the post who does not possess considerable strength of character as well as kindness and humanity.

For the first duty of an attendant is that of humanity towards the patients. However trying, however aggravating, however insulting, however filthy the patients may be, the first duty of the attendant, the foremost and most continually recurring necessity, is to keep his or her temper. It is not always easy, especially with the more rational patients, to bear in mind that they are out of their minds and not responsible for what they do or say; that allowance must always be made for them, and that they are not to be regarded as having the power to conduct themselves like sane people. It is not easy to keep this always in mind, but it has to be done. The attendant must **never** under any circumstances bandy words with a patient or exchange angry remonstrances, or allow himself to be put out of temper by anything a patient may say or do. Above all things no attendant must, under any circumstances whatever, strike a patient or punish one in any way. If a patient is mischievous and appears to misbehave wilfully, he or she is to be reported, but not corrected.

Attendants should understand that by striking or

punishing a patient they run a very serious risk of being prosecuted. The sections of the Act of Parliament which state the law on this point will be found at the end of this book in Appendix B.

Not only must an attendant not strike or punish or irritate or tease a patient, but he must not threaten him in any way nor attempt to frighten him. There must be no mockery, no jeering, no insulting or disparaging remarks on the appearance or conduct of the patients. The attendants must treat the patients openly and frankly, and not attempt to deceive them. There is no surer way for an attendant to lose the confidence of his patients, and his control over them, than by deception. It may answer for the moment, but never in the long run.

The first duty of an attendant, then, is to treat his patients with kindness and gentleness and humanity, both in deed and in word.

The law states that the objects for which an insane person is sent to a lunatic asylum are his CARE and TREATMENT; and this legal expression forms a good guide to the main groups into which the duties of an attendant are divided. His duties are the **Care** of the patients and the **Treatment** of the patients; and in addition to these duties towards the patients, he has to maintain cleanliness and order in the wards of the asylum.

The care of the insane may be divided into :—

1. Care of their Safety.
2. Care of their Cleanliness.
3. Care of their Comfort and Welfare.

Their treatment resolves itself into :—

1. Treatment of their Mental Disorders; and
2. Treatment of their Bodily Disorders.

We will now take each of these subjects separately, and describe the duties of attendants in connection with each one.

THE ATTENDANT'S COMPANION.

CHAPTER I.

CARE OF THE SAFETY OF PATIENTS.

The peculiarity of the duties of attendants in asylums is the minute attention that they have to pay to little things. Matters which in an ordinary household are of only the smallest importance become matters of life and death in lunatic asylums. Whether a man keeps his pocket-knife in his coat pocket or his trousers pocket may seem a matter of no importance at all; but if an attendant in a lunatic asylum keeps his knife in his coat pocket, and takes off his coat to do some piece of work, a patient may take the knife out of the pocket and cut his own throat with it. Whether a girl throws a broken stay-busk or a steel out of her dress on to the rubbish heap or not, may seem a matter of no importance; but if an attendant in an asylum does so, a patient may pick up the bit of steel, may make a knife of it, and kill himself therewith.

Whether a coal-box is kept locked or left open, may seem to be unimportant; but if left open a patient may take out the shovel and kill another patient therewith. In a lunatic asylum every trifle becomes a matter of importance. An attendant must keep his wits always on the alert, and must keep continually in mind the tendencies that lunatics have to injure themselves and others, both from design and from carelessness.

The safety of patients may be imperilled in five different ways:—

a. They may wilfully injure themselves.
b. They may be wilfully injured by other patients.
c. They may, in an outbreak of violence, be injured by the means used to restrain them.
d. They may be injured by accident.
e. If epileptic, they may suffer injury in their fits.

SUICIDE.

There is only one way of preventing a patient from committing suicide. This way is not absolutely effectual, but it is nearly always effectual, and nearly every suicide that takes place in asylums is due to the breach of this rule: that **a suicidal patient must never be allowed out of sight.** If a patient is suicidal he is **never** safe. Under no circumstances whatever, for no purpose, upon no pretext, must he be allowed to escape from supervision.

not even for a minute. Only so long as the patient is actually in sight can the attendant feel secure that no suicidal attempt is being made.

Under ordinary circumstances it is not difficult to maintain continuous supervision over a patient, provided that the asylum is properly constructed and that the attendants are sufficient in number. The occasions on which supervision fails, and on which suicides occur, are when sudden and unforeseen emergencies arise, or when the day attendants are replacing the night attendants, or *vice versâ*, or on any occasion when the usual routine of the wards is interfered with. It must be remembered that determined suicides are ever on the watch to carry out their purpose, and the relaxation of supervision, even for a moment, may give them the opportunity for which they are always looking. The following cases, which have actually occurred, will help to impress upon attendants the importance of continuous supervision, and to point out to them the occasions on which supervision is most likely to fail.

Case 1.—A patient in the Northampton County Asylum was put to sleep in a single room. He was known to be suicidal, and the attendant had orders to visit him every twenty minutes. He was seen at 2.25, when he was lying on his back, and appeared to be watching the attendant through the open door. At 2.35 the same attendant found him in a strange position, and it was

discovered that he had suffocated himself by plugging his throat with strips of flannel from his shirt.

In this case no blame attaches to the attendant, but it shows, first, that no amount of watching is any good unless it is quite continuous ; and second, it is an instance of the ingenuity with which suicidal patients will find means of killing themselves even when all weapons and instruments are removed out of their reach.

Case 2. — A female patient committed suicide on March 2nd, 1886. On admission she was considered to be suicidal, and a printed order was issued that she must be constantly and carefully watched, and never allowed out of sight of an attendant. The nurse in charge of her was sweeping the floor of the day-room when a troublesome patient seized the broom from her hand and ran off with it. The nurse, thrown off her guard, followed this patient and found her engaged in a struggle with another attendant. The result was that the day-room was left for about twenty minutes without any nurse, and on the return of the nurse, the first patient was found dead on the floor of the water-closet, with a piece of linen tied tightly round her neck.

It was exceedingly natural that the nurse should run after the patient who had taken her broom, and should stay to help the other nurse in her struggle ; but in view of the fact that she had a suicidal patient under her charge she should not have yielded to the impulse that prompted

her to recover her broom. She should have blown her whistle, and left the recovery of the broom to others. When an attendant has the care of a suicidal patient, the supervision of that patient takes precedence of all other duties. Whatever other duties the attendant may have that clash with this one, those duties must give way and be neglected rather than that a suicidal patient should have opportunity to carry out his purpose.

The following case illustrates another of the ways in which the supervision of suicides is apt to fail.

Case 3.—C. E., a female patient in the Devon Asylum, who was known to be suicidal, and was ordered to be kept under continuous supervision, was allowed by the night nurse in charge of her to get up and dress herself, and leave the dormitory to go into the water-closet block at six a.m., just as five day nurses were entering the ward to take charge of the patients ; none of these nurses, however, had seen the patient up, or were aware that she had passed into the lavatory. C. E. entered the slop-closet, and although the window was blocked, she squeezed herself through the open part, which was only five and a-half inches in width, and threw herself into the court below, receiving injuries from which she died almost immediately.

This case is instructive in several points. The night nurse took for granted that the day nurses, being in the ward, were now responsible for the patients, and that her

task was at an end. The day nurses did not know that the patient had gone to the lavatory. The opportunity occurred just as the change of nurses was going on. This is precisely the time when observation is most likely to be relaxed—a fact of which the patients are very well aware, and of which they are always ready to take advantage. **Second,** it illustrates the fact that the favourite hours for suicides to make their attempts are the early hours of the morning. These are the hours at which depression of spirits usually occurs even in healthy people, and it is natural, therefore, that in those who are suffering from melancholy, the malady should reach its greatest depth at that time. **Third,** it illustrates the tendency of suicidal patients to choose the same method of committing the act that they have chosen in a previous attempt; for this patient was known to have tried previously to throw herself out of a window. **Fourth,** it shows how very brief an absence from supervision may be sufficient for a suicide to effect his purpose.

The night nurse was to blame for not calling the attention of the day nurses to the fact that the patient had gone into the lavatory.

The following case also shows how very important it is that the night attendant should, before going off duty, examine every patient, and should not leave the ward until every patient is up and about.

Case 4.—A female patient in Prestwich Asylum was

found dead in bed by the day attendant when she came on duty at ten minutes past six. She was lying with her face on the pillow, and was, no doubt, suffocated. This patient had been visited frequently during the night, and the night attendant said that she was alive and sleeping at half-past five. This was confirmed by the head night attendant. "The attendant," say the Commissioners in Lunacy, "had neglected a most essential part of her duty, that of examining every patient and noting their condition before giving over their charge to the day attendants." She had been for several years in charge of the epileptic dormitory, and had given every satisfaction, but it was thought right to discharge her for this neglect of duty.

Case 5.—M. P., a patient in Colney Hatch, committed suicide in 1880. One nurse had charge of thirty-nine patients in an observation dormitory. Another nurse had charge of a patient in labour in a single room off the observation dormitory. When the child was born, the first nurse was called out of the observation dormitory to assist. During her absence M. P. got up, stood on a chair, lit a piece of paper by the gas, set fire to her bed-clothes, and got into bed. She died two days afterwards. She had previously tried to set herself on fire.

This case illustrates very clearly the danger that attends any interruption or interference with the customary routine of a ward. It is on such occasions that the majority of suicides and accidents occur. It was the

unwonted circumstance of the patient being in labour, and of the nurse being in consequence called away, that gave M. P. her opportunity of committing suicide. It illustrates also the tendency of suicidal patients to choose the same means of self-destruction that they have chosen before. This patient was known to have tried to set herself on fire on a previous occasion, and this fact was a clear warning of what she was likely to do again.

In order to maintain supervision over the patients, and to obtain certainty that all are safe, they should be periodically **counted.** They should be counted out of the dormitories in the morning and into the dormitories at night. Every party of patients that leaves the ward should be counted as it goes out and again counted on its return. When the patients go into the airing courts they should be counted, and as they return they should be counted again. Parties of patients who go out to work in the grounds should always be collected and counted **on the ground where they work,** then taken in and counted again into the ward. From neglect of this precaution it has often happened that a patient has slipped away from a working party, and that his absence has not been noticed until the party had reached the ward, ample time being thereby given to the runaway to escape or to commit suicide.

Walking parties should always be accompanied by at least two attendants, one of whom should walk near the

front of the party and the other quite the last of all. The first can then guide the party into the proper directions, and the last can maintain supervision over all and note any stragglers. The patients should be counted, not only on starting and returning, but also at the turning point of the walk, when the furthest point is reached.

While continuous supervision is an absolutely essential precaution in every case of suicidal tendency, and while no other precaution is of the slightest value without this one, there are other precautions which also must be taken, and which it is very necessary should be strictly enforced.

It is most obviously necessary that every facility for self-injury should be kept out of the reach of the patients; not only of the suicidal, but of all the patients in the wards, for a weapon or instrument is easily transferred from hand to hand, and if one patient in a ward has access to it, it may be taken for granted that any patient has access. For this reason the following rules must be strictly observed. The attendants must keep the doors of their rooms always locked. Those who have razors must keep them locked up in a drawer or box, and must never lend them, even to each other, nor must they use them except in their own bedrooms. The following case shows the importance of this precaution.

Case 6.—An attendant in the Durham County Asylum asked the charge attendant for his own razor, which was kept locked up by the charge attendant in a store-room in

the ward. This attendant, after shaving himself in the store-room, did not return the razor to the charge attendant to be locked up, but, believing he had concealed it, left the store-room open and went to his bedroom. The charge attendant shortly afterwards found a patient in the store-room in the act of cutting his throat with the razor, and was too late to prevent him from completing his purpose.

Case 7.—An attendant at Bethlehem had been shaving himself in a bath-room, and having finished, he left the bath-room, razor in hand. At the door he was met by a patient, who immediately attempted to get possession of the razor. In the struggle the attendant was badly wounded, and the patient eventually succeeded in obtaining the razor, and with it he instantly cut his own throat and died. Even continuous supervision is, therefore, not always successful.

The occurrence of disasters like these raises the question whether razors should under any circumstances be allowed to be kept in rooms leading directly out of the wards of asylums. There seems to be no valid reason why their introduction to the wards should not be absolutely forbidden, nor why those attendants who shave should not attend the barber's shop for that purpose, instead of conducting the operation in their own rooms.

Female attendants should be as careful of their hairpins as male attendants of their razors. Hairpins may become deadly weapons for patients to injure themselves with.

They may be swallowed or driven into various parts of the body. No attendant should carry a knife or a pair of scissors except it is attached to his body by a chain. Every attendant is furnished with a belt and chain to which his keys are attached, and on this chain should be carried his knife and scissors. There will then be no danger of his losing them, of having his pocket picked of them when, perhaps, he has taken his coat off, nor of his laying them down and forgetting to pick them up again.

Patients should not be allowed to go into the attendants' bedrooms under any pretext whatever. Attendants are naturally less careful in the privacy of their own rooms, and it is inevitable that they should sometimes leave lying about objects which it would be most undesirable for patients to get hold of. Female attendants especially are apt to take patients into their rooms in order to get some dressmaking surreptitiously done. This should never be allowed.

Case 8.—At the Macclesfield Asylum, in 1880, a nurse took a patient into her bedroom to reward her with some sweetmeat for her services in making beds. The window was unstopped and wide open. The nurse then took the patient out of the room, but left the door unlocked. While the nurse's attention was diverted, the patient went back into her room, drank some poisonous liniment out of a bottle standing on the table, and then threw herself out of the window, and died shortly after.

The knives used at the patients' meals are to be kept locked in a box, and to be counted out of the box before each meal, and at the end of the meal counted back into the box. The charge attendant only should have the key of this box, and should be responsible for the knives. The box is itself kept in a locked cupboard, so that there is the double security in case one of the locks should get out of order, as locks in asylums have a habit of doing. Knives must of course not be entrusted to the patients to clean.

Case 9.—In the Leicester County Asylum, in 1881, a patient obtained a carving-knife from the patient who was cleaning it, and with it cut her throat and died.

Knives are not, however, the only instruments with which patients can wound themselves. Broken glass is also extremely effectual for this purpose, and therefore, when any glass is broken, the fragments should be carefully collected and immediately removed from the ward. When a window is broken, not only should the fragments that have fallen be collected, but the glass remaining in the frame should be immediately pulled out, and the whole removed from the ward. The broken glass must not be laid down out of the hand of the attendant before it is taken out of the ward. The same rules apply to broken crockery.

Patients display much ingenuity in manufacturing cutting instruments, often for innocent purposes; but

whatever the purpose for which they are made, they must not be left in the patients' possession. To guard against this possibility the clothes of every patient must be searched every night, when the patients go to bed, to discover whether they possess any article of the kind. Bits of iron that they find about the grounds or in the road, pieces of barrel hoop, bits of tin, and the like, are carefully shaped and sharpened by grinding on stones; handles are adroitly made with wood and string; and every asylum contains a collection of weapons, more or less formidable, made in this way by patients, and capable of inflicting terrible injuries. Stay-busks and the steels from women's dresses should never be thrown on rubbish heaps, where they may be found by patients.

Patients who are actively suicidal should have, not only their personal clothing, but their bedclothes, searched every night. Knowing that their personal clothes will be searched, they often conceal weapons among the bedclothes.

Next to knives, the most formidable instruments for the purpose of suicides are tapes. No attempts at suicide in asylums are commoner than those by strangulation, and for this purpose a tape is the handiest and most convenient implement. For obvious reasons it is usually on the female side that they are employed. Tapes, therefore, should not be used in the construction of the dress of female lunatics. It is easy to substitute buttons in every situation in which a tape is ordinarily employed

and the addition of an extra buttonhole will allow of that adaptability which is the chief reason for the use of tapes.

Hairpins are, of course, not used by patients, their place being taken by tapes. These tapes should be taken off at night, counted, and kept outside the dormitories till morning.

Several instances have occurred of the use for suicidal purposes of the cords that unite the legs of step-ladders. For this and other reasons step-ladders should always be kept locked up, and notice should be taken that the cords are in their places. If missing they should at once be searched for till found.

It is impossible to deprive patients of all the materials that may be used for the purposes of strangulation and hanging, and the most that can be done is to keep from them those things, such as cords, tapes, and strings, that obviously suggest themselves for such a purpose, and to trust to supervision for the rest. The following are some of the materials that have been used for hanging or strangulation :—Scarf, strips of dress torn for the purpose, braces, bandage, dress lining, garters, bootlaces, handkerchiefs, blind cord, round towel, string, sheet, ravellings of stockings, webbing, window-sash cord, neckerchief, apron, petticoat string, binding of mackintosh sheet, sleeve of dress, piece of wire, strips of sheet, threads pulled from sheet and twisted into cord.

In view of the dangers attending the use of tape, and the great number of suicides that have been effected by its means, this material should not be used for garters, strips of old underclothes that have been thoroughly worn out and are incapable of standing any strain, being used instead. A still better plan is to have the stockings knitted in such a way that they will support themselves, and garters will not be required, or to have the stockings attached to some part of the clothing by a clip.

Another means by which patients are apt to injure themselves is by fire. Attendants should be scrupulously careful of their matches. Each attendant should have but one match-box, and should never allow this to leave his possession for a moment. Attendants should use those matches only which are issued to them from the stores. Patients will be continually bothering for lights to their pipes. When a light is thus needed, a match should be struck and given to the patient, and the attendant should see that it is put out as soon as the pipe is lit, and not thrown away while still alight.

Fire-guards should be kept locked, and any damage to their locks should be instantly reported.

Case 10.—In the Carmarthen County Asylum a patient opened a fire-guard, the key of which had been lost and the loss not reported, and set fire to her clothing, causing injuries of which she died. The attendant should have had the key on the chain with the other keys. It could

not then have been lost; but having been lost, the loss should have been instantly reported.

Patients must not be allowed to light fires, nor to sweep up the hearths, nor to put coal on. In mending the fire, care must be taken not to pile the coal high above the bars; it will be very apt to fall off and set fire to the carpet or floor, or whatever is near.

Gas-jets should be high up and out of the reach of the patients; where not so situated, patients must not be allowed to remain in sculleries, closets, or lavatories in which gas is lit without an attendant being present.

Water as well as fire is occasionally used as a means of self-destruction, and for the purpose of a suicide it is by no means necessary that the water should be deep. Water out of which a child could wade with ease may be quite deep enough to drown a suicide. If it be not deep enough to cover him when standing or sitting, he will lie down in it rather than miss his chance of putting an end to himself. Hence the utmost care must be taken to allow no patient access to a bath-room alone.

Case 11.—At the Nottinghamshire County Asylum, in 1887, a patient succeeded in drowning himself in a bath. The water in the bath was less than two feet deep. The body was discovered face downwards in the water, the head being prevented from rising by the weight of a large piece of coal tied up in an apron and fastened round the neck, the rest of the body floating.

Nothing in the attendant's duties is more important than the safe custody of the bath keys, and the proper observance of the rules for bathing given further on. For the present it will be enough to state the following rules, which must be observed with the strictest faithfulness :—

The attendant must keep the bath key in his own possession, must himself turn the bath on and off, and must never entrust this duty to a patient.

No bath must have water in it unless an attendant is present. So long as there is water in the bath the attendant must remain in the bath-room, and when the water is allowed to run away the attendant must not leave the room until the bath is empty.

When a bath is not in use, **the waste must always be left open.** If it is closed, and one of the supply valves happens to leak never so little, the bath will gradually fill, and in this way a patient will obtain an opportunity of drowning himself which will be quite unexpected, since the attendant knows that he has seen the bath emptied and removed the key.

Unless these rules are strictly observed, the safety of the patients is not assured.

The ways in which suicide and self-injury may be attempted are very numerous and diverse, and against some of them it is almost impossible to guard. One patient will fling himself head foremost down a flight of steps; another will run his head violently against a wall;

a third will gouge out his eye with his fingers, or shut his thumb in the crack of a door. Every attendant should therefore keep always in mind the fact that many patients are disposed to suicide and self-injury, and should keep his wits about him to notice anything which seems to offer facilities for such a purpose, and should endeavour to guard against it. It should be needless to say that he should be particularly careful to keep all medicines and lotions under lock and key, and never under any circumstances allow a patient to handle either the one or the other.

Every medicine should be given to the patients by the attendant himself, and not entrusted to another patient to carry. The attendant should see the patient swallow the medicine. Patients have been known, when this precaution was not taken, to save up their sleeping-draughts until they had accumulated a poisonous quantity, and then to take the whole at once.

In most asylums slips of parchment are delivered to attendants with the patients who are actively suicidal. These parchments contain the special precautions that are to be taken in each case. On receiving such a parchment the attendant is to **read** it, and make sure that he understands the whole of it. He is then to **sign** it in proof that he does understand it. When he gives up the charge of the patient to another attendant he must give up the parchment also, and the other attendant must read it and sign it.

CHAPTER II.

VIOLENCE.

The second source of injury to patients, against which attendants have to be on their guard, and protect them, is the violence of other patients. What has already been said about the necessity of keeping weapons out of the reach of suicides applies to the case of homicides also; and some additions are here necessary, since there are weapons used for the purpose of injuring others, which are never used for the purpose of self-injury. Violence is much more often committed by **striking** than by cutting or stabbing, and practically the only weapons which the homicidal lunatic makes use of in asylums are those with which blows can be struck.

The handiest of these weapons is the poker, which is a very deadly instrument in the hands of a violent lunatic, and should never, therefore, be allowed in the wards of an asylum. Whatever rearrangement of the fire is necessary

can be done with the shovel, the poker being in reality a wholly unnecessary implement for ordinary fires, and leading only to waste of coal and injury to fire-grates. The shovel itself is, however, a formidable weapon, and should, therefore, always be kept locked up in the coal-box, and care should be taken that the lock of the coal-box is always in good order. Any defect should be reported immediately. Towel rollers, where roller towels are used, are deadly weapons. When used in asylums the rollers are made to lock into their places, and care should be taken that this is always done. Brooms should be kept locked up when not in use. Broken chairs should at once be removed from the ward.

Perhaps the most formidable weapons used by patients are those which they construct for themselves by the simple expedient of tying a large stone in a handkerchief, or dropping one into the toe of a stocking. Fearful injuries have been inflicted by these means, and it is obviously difficult to prevent such a weapon being constructed. A patient who would make use of such means will usually watch carefully for a good opportunity of using it, and during the interval between making and using the weapon may be discovered. This is an additional reason for the imperative rule that every patient's clothes should be searched every night.

Even without any weapon, a patient is able to inflict

severe injury upon his fellows if he be disposed to be violent, and these injuries may be inflicted, not only in fights and struggles—as to which the attendants are usually sufficiently upon their guard—but also by slight blows and pushes which do not appear serious. It must be remembered that very many of the inmates of asylums are advanced in years, and the bones of old people are easily broken. It must also be remembered that the bones of some patients, and especially of those suffering from general paralysis become unusually brittle, sometimes extraordinarily brittle, and a knock or a fall which would be of no consequence whatever to a young person in ordinary health, may readily break some of the bones of such patients, and produce very serious injuries. It should, therefore, be an invariable rule that every struggle, and every fall, and every blow, however trifling in severity, should always be noticed in the charge attendant's daily written report; and that the attention of the medical officer should always be at once called to a patient who has suffered a blow or a fall, or been engaged in a struggle. The following cases illustrate the importance of these rules.

Case 12.—At Bethlehem Hospital, in 1887, a patient, W. S., provoked another patient, and was struck by the latter at least one blow, which cut his nose. Six days later W. S. was ill with fever, and in a fortnight he died of blood poisoning, and was found to have three broken

ribs. He was a general paralytic, and his bones were very brittle.

Case 13.—At Bicton Heath Asylum a patient was knocked down in the airing court by another patient. He made no complaint of being hurt, but two days afterwards he was noticed to be looking ill, and on examination the medical officer found that he was suffering from fractured ribs. In six days he died, and after death was found to have twelve ribs broken.

Case 14.—At the Burntwood Asylum a patient, G. H. S., suddenly rushed at the night attendant, who struggled with him, and fell with him over the mattress, which was on the floor, on to the ground, the attendant being uppermost. This conflict was so brief that another attendant did not think it necessary to come forward, nor did the attendant engaged in the struggle think it worth while to report the matter. Three days afterwards, however, the patient was noticed to move as if in pain, and upon examination there was found a bruise on his chest and signs of fracture of several ribs. On the following day he died, and was found to have ten ribs broken.

Case 15.—At the City of London Asylum, in 1890, a general paralytic climbed over some iron railings and fell on the other side; he recovered himself, climbed another railing, and again fell. No formal report of the circumstance was made, and the patient was not examined,

though he was put to bed. Two days afterwards he was found to have broken ribs, and in four days he was dead.

No comment is needed in these cases, and nothing that could be said could add to the impressiveness of the lesson they teach—that every tussle that a patient is involved in, every blow and every fall that he incurs, should be instantly reported to the medical officer.

Incidentally, Case 14 illustrates the danger in which patients stand from the means which are used to restrain them from committing deeds of violence on others.

There are few asylums in which injuries have not been received by patients under these circumstances. Some of these injuries have doubtless been unavoidable, but some have been inflicted by undue and excessive violence used by attendants, and more by unskilfulness and ignorance of the methods that should be used to restrain violent lunatics. The following are the rules to be observed on such occasions :—

The most important rule in dealing with violent lunatics is, never, where it can be avoided, to enter upon a struggle single-handed; and the next, which is on the same principle, is, instantly to go to the assistance of any other attendant who is engaged in a struggle. Numbers must prevail against even the strongest man, especially when the strength of the numbers is guided by intelligence and method. Moreover, it is a very common

occurrence that when a lunatic recognises that the force opposed to him is overwhelmingly great, he throws up the sponge at once, and ceases to engage in a struggle which must manifestly be hopeless. For this reason, when a very violent patient is to be fed or washed or dressed, three or four attendants should go to him at once.

Under no circumstances should an attendant be left singly in a ward in which there are patients inclined to be violent. Should an attendant be so left, the responsibility for any injuries suffered by him or by any patient in the ward will lie with the attendant who last quitted the ward.

In dealing with a refractory patient, the object is to render him powerless for mischief, while at the same time the infliction of any injury upon him is to be carefully avoided. Should the attendant unfortunately receive a blow from the patient, he must on no account return it, nor must he allow himself to lose his temper with the patient in consequence. He must endeavour to look upon the matter as if he had been struck by some piece of machinery or other inanimate object, and direct his endeavour, not to retaliation, but to rendering that object harmless.

When an attendant sees a patient making an attack upon anyone else, he must instantly drop whatever he is doing and run to the assistance of the person attacked.

blowing his whistle at the same time. In tackling the aggressive party he should invariably approach him from **behind**, and should make it his endeavour to seize his right wrist. If, however, the right wrist is already in the custody of the person attacked, he should seize the left. Then, using both his own hands for the purpose if necessary, he should quickly pull the hand down and backward until it is well behind the aggressor's back. He should then bend it up so that the hand rests in the middle of the back below the shoulder-blades, the back of the hand against the coat; hold it there firmly, taking at the same time a good grip of the back of the coat. This arm will then be quite powerless. Meanwhile, another attendant will do the same with the other arm, and with the two hands thus secured behind his back the patient is helpless.

He should then be taken to a settee or low arm-chair—the settees with arms are the best—and made to sit therein, his hands being held secured by twisting the cuff and holding it down to the arm of the seat. An attendant sitting on either side should place a leg over the nearest leg of the patient, who is then perfectly secured from any aggression beyond spitting.

If the patient is extremely violent, and the aggression take place in the airing court, or where there is no seat near in which he can be placed, he may be laid on the ground, being pulled backwards by the shoulders and

laid gently down. He must on no account be thrown down, nor must he be put on the floor by an attendant standing in front of him. If this be done, the attendant is almost sure to fall upon him, at the imminent risk of fracturing the patient's ribs.

Very many of the broken ribs and other casualties that take place in asylums are owing to the fall of the attendant on to the patient in a struggle for mastery. One such case, that of G. H. S. at Burntwood Asylum, is given on a previous page, and the following is another instance.

Case 16.—T. C., a patient in the Garlands Asylum, was requested one night as usual to undress. He rose from the bed as if to do so, and then suddenly rushed at the attendant, and a severe struggle ensued. Both men fell upon the bed, and over it between two beds, and the knees of the attendant struck T. C. on the abdomen as they fell. Two other attendants then arrived and released the one first attacked, and held the patient for five minutes until the excitement passed off. No blow was struck, but the patient died four days afterwards, and it was discovered that his bowel had been ruptured. The attendant should have eluded the first rush of the patient, and blown his whistle, and then, with the assistance of the other attendants, overpowered him.

When a patient is on the floor he is comparatively powerless. It is advisable, therefore, to keep him there

until his excitement has passed off sufficiently to render it safe to let him rise; but in keeping him down it should never be forgotten that, **under no circumstances whatever should a patient be knelt on.** More broken ribs and broken breastbones are due to this practice than to all other circumstances put together. When a patient is put on his back by the means already described, or by any other means, an attendant should immediately **sit** on his legs just above the knees, while two others should hold the arms at the wrists in the crucifixion position. It will be quite impossible then for the patient to move. It is an extraordinary thing, but whenever under these circumstances—that is to say, having put a patient on his back—I have told an attendant to sit on his legs, the attendant has invariably **knelt** upon them, and has had to be made to correct his position. The advantage of sitting on the legs is obvious. Kneeling on a man's legs hurts him. Sitting on them does not. Kneeling is a very insecure position, and it is comparatively easy for the patient to throw the kneeler off and to get his legs free. But if a man is sitting on your legs just above the knee, and thus pinning them down to the floor, it is most difficult to throw him off; and if he is sitting astride, it is practically impossible, unless you are free to wriggle your body about; and with the arms outstretched and the hands held down to the floor, it is quite impossible. By adopting this method of restraint it is impossible to injure the

patient, and at the same time he is not only prevented from doing harm, but he is reduced to such a state of utter helplessness and impotency as has usually a most salutary effect upon him.

If an attendant is attacked by a patient with a weapon in one hand, such as a stick or a fire-shovel, he should seize with his right hand the wrist of the hand that holds the weapon, and with the left hand he should hold the weapon as far from the patient's hand as practicable. The patient will be powerless to strike him with the weapon, and may be thus held till assistance arrives. If the weapon is a broom, the broom should be seized near the patient's hand, and the grasp rapidly shifted to near the head of the broom. If the patient is extremely aggressive, and the weapon a formidable one, and if the attendant is directly attacked, it may be impracticable to seize the patient until a blow has been delivered and the weapon lowered. In that case a chair held by the back forms an efficient defence for the moment.

In every case, the moment a patient has been mastered, take off his boots. He is then comparatively harmless; but so long as he has his boots on he possesses a pair of deadly weapons.

It is to be thoroughly understood that these means of securing a patient are not to be used unless the patient is actually attempting violence. So long as he is merely excited and raving, and even threatening, he is to be left

alone, and the more completely he is left alone the better. Best of all if he can be turned out into an airing court by himself.

The means of restraint above given are to be used only to prevent actual injury to some person, and are not to be maintained for one moment longer than is necessary to prevent such injury. Two or three minutes will usually be quite enough to keep a violent patient in the attitudes described.

Note.—In the case of general paralytics, whose bones are often very brittle, and in all cases where the strength of the patient is not very great, and especially with women, whose wrist bones are small, it is advisable to seize them by the cuff of the dress instead of by the wrist, for fear of breaking the bones.

CHAPTER III.

ACCIDENT.

The fourth kind of injury to which patients in asylums are liable is that which is accidental, or which is not inflicted either by themselves or by other people. Insane people, and especially demented people, are especially liable to accidental injury as a direct consequence of their infirmity, which renders them unable to foresee or to provide against those common sources of danger which beset all of us in our daily life. Many of the inmates of lunatic asylums are so infirm in body, either from age or from the effect of their malady, that they are liable to grave injury from trifling causes, and thus, for one reason on another, the majority of asylum inmates are far more liable to accidental injury than are people in the world outside, and constant vigilance and special attention are required to prevent the occurrence of accidents.

Falls are common sources of injury. Old and feeble patients are liable to trip and fall :—*a.* if the floor is highly

polished; *b*, if there is any irregularity in the floor; *c*, in going up and down steps; *d*, when jostled by a crowd of patients going in or out of a door; *e*, when their foot gear is not attended to; *f*, when getting out of bed.

It is a common practice in asylums to have the floors polished, and very nice they look when so treated, and, moreover, they are easily kept clean. Attendants, from a very laudable desire to keep their wards as well as possible, will have these boards rubbed and polished until they shine like glass, and are equally slippery. Under such circumstances, they are highly dangerous for old and infirm people to walk over. Boards should, therefore, not be polished in infirmaries, nor in those wards which are inhabited by the aged, and no boards should be highly polished. When the floors are of nine-inch boards which have not been well seasoned before being laid, they are apt to warp, and from the custom of frequent scrubbing, and consequent dampness of the upper surface, they usually, in asylums, warp so that the upper surface of the board is convex. If such a board is polished, and is covered by a mat or a strip of loose carpet, it becomes a most dangerous trap. The moment the mat or carpet is stepped on, it slips off the polished curved surface of the board, and a heavy fall is the result.

Irregularities in the floor are a fertile source of accidents, especially worn carpets and worn cocoanut matting. When either of these materials is worn through, a hole is

formed which is surrounded with loops, forming veritable snares for the feet. Cocoanut matting should never be used in asylums under any circumstances, and if any attendant is unfortunate enough to have the floor of his ward covered with it he must keep a constant look-out for holes, and repair them the moment they are perceived. He must not wait to report the matter, but keep packthread and stout needles by him, and repair it himself at once. Equally dangerous are those mats known as "sinnet" or "skeleton" mats, made of rope or cocoanut fibre. They should never be used, for they soon show wear, and the first sign of wear is the formation of loose loops, in which the foot is extremely apt to be caught. The edge of a loose carpet is an occasional cause of a fall; and sometimes, when boards are much worn, a knot or the edge of a new board projecting above the surface will constitute a source of danger.

Feeble patients should always be accompanied in going up and down steps, especially when they are demented as well as feeble, for it occasionally happens that they fail to observe the last step, and a disastrous fall is the result. Such people are liable, too, to attacks of faintness and dizziness, in which they might not fall if on level ground, but which, occurring while going up or down stairs, might easily make them lose their footing. Steps are particularly dangerous if they are much worn or if they are very shallow. If the floor of a ward is just a couple of inches

lower than that of an adjoining ward, the step from one to the other will be a constant occasion of falls.

When patients are passing through a door, the old and infirm should always be passed through separately from the young and vigorous. Insane persons have rarely any consideration for others, even when intelligent, and a crowd of vigorous patients pressing through a door will have not the slightest consideration for any infirm member of the party, and will push him down and walk over him without thought and without mercy. When it is time, therefore, to come in from the airing court, the young and vigorous should be called in first; and when they have passed through and left the doorways clear, the old people should be collected together and brought in separately.

Door-scrapers when placed near doors are very dangerous. When a crowd of patients is pressing in to a door some are certain to trip over the scraper if one is near. Movable scrapers, if used, should, therefore be kept away from the entrances. The only fixed scraper that should be allowed is that which is flush with the surface of the wall, the wall being recessed for the foot. Should fixed scrapers projecting from the ground be near the doors, I should be the last person to suggest that attendants should break them, but they are certainly very liable to accident.

The duty of the attendants with regard to the clothing of the patients will be dealt with subsequently; but one matter must be mentioned here, since it may easily become

a source of danger, that is, care should be taken that the boots are not too long, An elegant, fashionable, perfect-fitting boot is not expected in a public asylum, but there should be some sort of proportion between the size of the boot and the size of the foot inside it. When the former extends beyond the latter for an inch and a half or two inches, it becomes what may be termed a "cheap tripper," and imperils its wearer's safety at every step. Similar consequences may happen if the stockings are allowed to fall down the leg and trail about the feet. The patient treads with one foot on the stocking of the other; the latter foot is fixed, and when she tries to take a step with it, down she goes.

Lastly, patients sometimes fall from faintness or extreme debility, from the unsteadiness of general paralysis. as well as from fits, which will be dealt with further on in their place. A common occasion for feeble patients to receive injury from falls is when they get out of bed unassisted in the night. General paralytics, in particular, are often very restless, and apt to get up and roam about at night, and are very likely to fall and hurt themselves when doing so.

Such being the causes of falls, let us now look at their consequences. Simple falls, such as we are now considering, occurring merely from weakness or from one of the causes considered above, and not being attended by any great violence, are often followed by no ill consequences whatever. But in old and feeble people, and

especially in those suffering from general paralysis, ill consequences do not infrequently follow, and the commonest of these consequences is fracture of the hip.

When a patient is seen to fall, the attendant should immediately go to help him up. He should not, however, lug him up as if he were a sack, but proceed with caution and judgment, and if the patient complains of pain in leg or hip, the attendant should immediately cease his effort, lay the patient down, and send for the medical officer. Fracture of the hip is sometimes very difficult to recognise; but if a patient is lying flat on his back with the legs straight out, and if the whole of the outer edge of either foot from the heel to the little toe is touching the ground it is quite certain that the bone is broken, and no attempt should be made to raise the patient until he has been seen by the medical officer. The bone may be broken even though this position is not assumed.

Next to fracture of the hip, the commonest injury from a fall is fracture of the wrist. When a person is falling forward, the natural and unavoidable course is to put out the hands to break the fall; and when the weight of the body comes suddenly on the hands the wrist is, in old people, often broken. Patients who are apt to fall should always sleep in an observation dormitory, or on a mattress on the floor of a padded room. It is no part of the duty of an attendant to arrange where the patients are to sleep, but when a night attendant has such a patient under his

care in an observation dormitory, he should never allow him to get out of bed unassisted. Injuries from this cause occur every year.

Case 17.—J. V., aged 79, a very feeble and demented patient, in the Colney Hatch Asylum, slept in a single room. One morning the attendant noticed a recent graze on his forehead, and his bedding was disordered. The medical officer was summoned at once, and found two ribs fractured. Four days afterwards the patient died. The coroner's jury found that he rose in the night for natural relief and fell, and thus fractured his ribs.

Case 18.—S. H., a general paralytic in the Menston Asylum, had been seen to fall more than once when rising from his bed at night. One day he complained of pain in his side, and two ribs were found to be broken. A month afterwards he died, and it was then found that, in all, four ribs were broken.

Next to falls, the most frequent source of injury to patients in asylums is **suffocation**, to which two classes of patients are especially liable—the first class is that of epileptics; the second, general paralytics. The suffocation of epileptics will be dealt with in the next subsection. General paralytics are especially liable to suffocation while at meals, for two reasons. In the first place, they suffer from partial paralysis of the tongue and throat, which impairs the natural arrangements for keeping the food out of the windpipe and directing it into the gullet, and, in

the second place, they are often very greedy and feed grossly and very fast. Thus they often get their mouths crammed and distended with excessive quantities of food, which even a healthy person could not swallow with safety; this food they masticate very imperfectly or not at all; and they then try to swallow it in great lumps, which their enfeebled throats are unable to dispose of.

The precautions to be taken are obvious. General paralytics who have begun to experience any difficulty in swallowing should be allowed soft food only. Their bread should be given in the form of bread and milk, or crumbled up, and their meat in the form of mince. To prevent them from cramming their mouths too full, they should, so long as they are allowed to feed themselves, be allowed no implement larger than a teaspoon. In more advanced stages they must be fed, and fed slowly.

It has been found by experience that the time when general paralytics are most apt to choke is when they have risen from table and are walking about with their mouths full, immediately after a meal. Care should, therefore, be taken that they have quite finished before they are allowed to rise.

Next to suffocation, the most frequent source of accidental injury to insane patients is **scalding**, and scalding invariably results from some breach of the rules for the management of the bath. If these rules are observed there is no possibility of accident of this kind happening.

The chief rules for the prevention of accidental scalding are—(1) Always to turn on the cold water first, and (2) never to allow a patient to have the key of the bath. Observance of these rules will render such an accident almost impossible, and it will become altogether impossible if there is added to them a third, viz.—The attendant should never leave the bath while there is water in it.

There is a form of valve now made for the supply of baths whose construction renders it impossible for the hot water to be turned on before the cold, and it were much to be desired that this valve should be fitted to every bath in every asylum. Until that is done, however, the rule, **cold water first,** should be so soaked into the mind of every attendant that he cannot possibly forget or disregard it. To allow a patient to have possession of the key of a bath is little short of a crime, and should render an attendant liable to summary dismissal.

Case 19.—At Burntwood Asylum an attendant was preparing a bath for a dirty patient. She turned on the hot water first, and left it filling to go and attend to another patient, leaving the door of the bath-room open. The dirty patient got into the bath, was severely scalded, and died eight hours after. Here the nurse broke two of the rules given above, and was grossly to blame for the result which naturally ensued.

Case 20.—At Winson Green a dirty patient was put into a bath, while both hot and cold taps were running as

well as the waste. She cried out, and was taken back to bed, when it was found that she was extensively, though not severely, scalded about the legs and buttocks. She died in about ten hours. Here the nurse, to save time, had turned both taps on together instead of drawing the necessary amount of cold first, according to rule. In the following case a patient died from a similar breach of the rule.

Case 21.—In the Macclesfield Asylum, in 1880, an attendant turned on the hot and cold water together, and left the bath-room and the patient who was to be bathed in the care of another patient. The first patient was put by the second patient into the bath, was badly scalded, and died ten days afterwards. Here there were two distinct breaches of duty. The hot and cold water were turned on together, and the attendant left the bath-room while there was water in the bath.

Case 22.—At Cane Hill, in 1889, the bath-room was left unlocked with the bath two-thirds full of boiling-water, which had been drawn for scullery purposes, the ordinary scullery supply being inaccessible for a few hours. This bath-room adjoined the ward lavatory, to which a patient was taken to be washed and changed, having been dirty. The nurse in charge of her, after partially undressing her, left her, for a few moments only, in charge of another patient, while she herself went to fetch clean clothing. The patient, seeing the bath in the adjoining

room through the open door, went to it, stepped into the water and slipped down into it. This case illustrates the danger which always attends any disturbance of the usual routine of the wards. Had the scullery water supply not been out of order the accident would not have occurred. Additional vigilance is always required when any customary arrangement is altered. This is illustrated by Cases 2 and 5 also.

The causes that have been enumerated are the source of nearly all the accidents that occur in asylums exclusive of those arising from fits, but sometimes accidents arise from other causes, almost always, however, from the breach of some obvious precautions, as in the following case.

Case 23.—A demented female patient in the Hants Asylum left her bed, and, finding the door of a store-room open, obtained access to a bottle of strong liquid carbolic acid, and drank the contents. She died in about half-an-hour. This patient was not suicidal, and probably took the poison merely as a drink because she was thirsty, for she was suffering from diarrhœa and had no access to liquid. In this case the nurse was doubly to blame: first, for leaving open the store-room door, and, second, for neglecting to dilute the acid with water as she had been directed to do. All poisonous disinfectants ought, however, to be diluted before being issued from the stores.

Injuries in Fits.

Next to suicides the greatest source of anxiety in an

asylum are the epileptics. In addition to the constant apprehension that they may injure themselves in their fits, they are as a class the most turbulent, quarrelsome, and intractable of asylum inmates. At the present time, however, we have to do only with the injuries to which their malady renders them liable.

The commonest of these injuries are, of course, the results of falls, since nearly every epileptic falls in his fits, and many fall headlong and with great violence. Great precautions must, therefore, be taken as to the positions in which epileptics are allowed to get, and as to the conditions under which they work.

This is the more necessary since epileptics are as a class strong, and hearty, and muscular, and afford some of the most useful and industrious workers that are to be found in asylums. Their ability and willingness to work leads sometimes to their being employed under conditions that are not safe for them. The following precautions are necessary in the employment of epileptics. They must never be allowed to mount above the surface of the floor. They must not stand on chairs or tables, or on ladders or steps; neither must they work in the neighbourhood of gravel pits, wells, or any steep declivity. They must not use sharp instruments in their work, nor must they work in the neighbourhood of unprotected fires nor of boiling water.

Case 24.—In 1881, a patient at Barming Heath was

walking on the top of the bank bounding the airing court when he was seized in a fit, fell down the bank and struck his head against the wall, fracturing his skull. He died next morning.

Case 25.—In the Somerset County Asylum a patient, while working in the laundry, had a fit, during which she immersed her arm in a tub of boiling water which stood near her. The scald was very severe; it suppurated profusely; and at the end of a year she died, partly from the effect of the injury.

Epileptics should never be allowed to go up or down stairs alone. Going upstairs the attendant should follow them; going downstairs he should precede them.

In most asylums hats are provided with padded rims for the use of epileptics, and in some cases these are useful in saving the head from blows in the terrible falls that are so common among epileptics. Attendants can foresee in many cases, from the altered demeanour or appearance of the patient, when a fit or batch of fits is likely to occur, and can take precautions accordingly. In every patient the fits maintain, as a rule, the same general character throughout his life, and by taking notice of the character of the fit, the attendant is often able to take precaution against injury. For instance, some patients invariably fall to one side, and always to the same side. The attendant will therefore take care that the patient's customary seat is so placed that in falling to that side he will

fall away from the fire, and from any hard or dangerous object. Other patients fall directly forward on their faces in such a way that it is impossible to save them from injury, and their faces bear the scars of many wounds. If it is possible to tell when the fits of such patients are likely to occur, they should be kept in bed when the fits are impending.

Besides the chance of injury in falls, there are two special dangers to which epileptics are subject, dangers so grave that no year passes without several deaths occurring in asylums by reason of them. Against these two dangers attendants need to be specially warned. The first is the danger of suffocation by turning on the face in a fit; and the second is the danger of suffocation by drawing, during the fit, partially vomited food into the windpipe. No amount of precaution or skill will always prevent the second kind of accident, but the first can always be prevented, and never ought to occur.

If a patient is suffocated by turning on his face in a fit. it means that there has been gross neglect on the part of some one responsible for his care.

This disaster never, of course, occurs in the daytime. In the day a patient never has a fit unobserved, and is always cared for. But in the night it may very easily occur, in even an observation dormitory. Many patients, on going into a fit, emit a loud cry, and so call attention to what is happening, and very many others give notice

by a gurgle in the throat, or a groan, or a snort, or some other noise, that they are seized in a fit; and at the termination of all fits of moderate severity the patient snores, and so gives warning of his state. But in some patients the fit occurs without any such warning. They go off quite quietly, and if such a patient has a fit a long way from the attendant, even in an observation dormitory, it may very easily escape notice, and the first thing that is known about it is when the attendant goes round and finds the patient on his face, stone dead. All patients who have these quiet fits ought, therefore, to sleep as near to the station of the night attendant as possible.

When a patient is seized in a fit, the attendant should take a pillow and lay it under the patient's head, at the same time loosening the dress at the throat and composing the dress and limbs decently. This being done, the patient should not be further disturbed, but should be allowed to sleep away tranquilly the effects of his attack, until he wakes and feels inclined to rise. Inexperienced persons frequently struggle with patients in fits, and in particular there is a curious superstition that the hands ought to be unclenched. It is not uncommon for a doctor to be told with awe that a patient "has had such a bad fit that it took six men to hold him!" and a bystander will boast with great satisfaction that he has "got his hands open." It is

scarcely necessary to tell any person who has seen half a dozen fits, that no possible good can be done by holding a patient who is in a fit, and that he can do no possible harm if left alone. As for unclenching his hands, if they are very tightly clenched, and great force is used in opening them, it is possible that his muscles may be torn in half by doing so, but no good result can possibly ensue. When a patient has a fit he should be left alone; but he should be looked after when he begins to come to himself, raised from the floor, and helped to a seat. Some patients are apt to become violent immediately after their fits, and these must, of course, receive special attention when they are coming to. It is very common for patients to wet themselves in fits. This should be looked out for when the patient comes to himself, and he should be changed if necessary, but nothing should be done so long as he is sleeping off the fit. In some cases in which fits are very severe or very frequent, the patient does not come to himself for many hours or days, or may even die without regaining consciousness. In such cases, of course, the patient must be put to bed as soon as it becomes evident that he is not going to come round soon.

CHAPTER IV.

EMERGENCIES.

Fire.—On the discovery of a fire the attendant will, if the fire is but small, instantly throw a bucket of water on it. If this does not at once subdue the fire, or if the fire is of such dimensions that a bucket of water would manifestly be insufficient to subdue it, the attendant immediately rings the fire alarm, and then, leaving the fire to be dealt with by others, proceeds to get the patients out of the ward. If the fire occurs in the daytime, there will be no difficulty about this. The patients are all up, dressed, and in their day-rooms, and the task is simply to get them out into the airing court as on ordinary occasions. But if the fire occurs at night, as fires are apt to do, the matter is very different. The first thing to be done is, as before, to set in action the fire alarm. Next, go to the bedrooms of all the attendants near and call them up. Then throw open the doors of the dormitories, and single rooms, and the doors of the special staircases, with which most asylums are provided to be used

in case of fire. Then call up the patients, and, leaving the more sensible and able-bodied to care for themselves, devote your whole attention to saving the infirm and demented. Should you be called by an alarm of fire to a ward not your own, set to work at once to get the fire hose to work.

1. Take a coil of hose off the hook on which it hangs. Carry it to the standpipe and drop it there. Raise the coil on its edge with the coupling lying on the floor, pointing to the standpipe and away from the fire. Unstrap the hose, and roll it towards the fire, until all is unrolled. Take care in going round corners to make a wide sweep and not a sharp turn, or the hose will kink and may burst when the water is turned on. Another coil is now dropped at the end of the first length of hose, and the same operations repeated until the scene of the fire is reached. To couple the hose to the standpipe, stand astride the hose facing the standpipe, lift the end till the coupling is six inches higher than the screw to which it is to be attached, grip the hose between your knees, apply the coupling to the screw and screw it up, tightening with the spanner. To couple one length of hose to another, stand astride the hose nearest to the standpipe, with your back to the standpipe, lift the male screw and grip the hose just behind it with your knees, apply the female screw and screw it up, turning **from right over to left.** Tighten with spanner.

If the hose is already at work when you get to the scene of the fire, help to get the patients to a place of safety.

Fire.—If a patient's clothing is actually on fire, the attendant must wrap round him a blanket, carpet, curtain, hearthrug, quilt, or any piece of woollen drapery that is ready to hand.

Suffocation.—When a patient appears to be suffocating, do not waste time by slapping him on the back. Send instantly for the medical officer. Stand on the patient's right side, and with your left hand take a firm grip of the hair on his crown. Bend his head back till his face looks straight up to the ceiling. Put your right forefinger into his mouth, and, getting your hand round to the **side** of the mouth that is nearest you, insert the finger as far down the throat as you can, feeling for the substance that is choking him, and trying to hook it up with your finger. At the base of the tongue is a gristly valve projecting backwards into the throat, and covering the top of the windpipe. The use of it is to prevent the food from slipping into the latter. It is not difficult to get your finger under this valve, and to feel whether the top of the windpipe is clear or no. If you do not succeed in getting away the substance that is obstructing the breathing, you can at any rate press on the base of the tongue as far back as possible with your finger, and thus cause the patient to vomit, when he will

very likely throw up the substance that is choking him. *Note.*—It is advisable, before putting the finger in the patient's mouth, to wrap it round near the knuckle with a handkerchief, towel, duster, or apron, or you may get it badly bitten.

Fainting.—The usual treatment when a patient faints is to sit him upright in a chair, and hold him there. This is the worst thing that can possibly be done, except trying to stand him upright. A person faints because he has not enough blood in his head. To make the blood flow to his head again lay him flat on the floor with nothing under his head. Give him plenty of air, flip cold water on his face and chest by dipping your fingers in water and shaking them smartly at him. Do not **pour** water on him, and do not flip him with a wet towel. You may easily make bad bruises and wales by so doing.

Wounds.—Bleeding from a wound can always be stopped. Remember that. Never waste time by holding the bleeding part over a basin and slopping it over with water, which is the usual treatment of bleeding adopted by ignorant persons. Look where the blood is coming from, and put your thumb on that spot; at the same time grasping the limb, if the wound is on a limb, with your fingers. It is not necessary to press hard. A gentle pressure will suffice if you get your thumb on the right spot—that from which the blood is coming. If the wound is on the head, cut the hair as close as possible

for an inch all round the wound. If the wound is very severe, and bleeding from several places, or if you cannot stop the bleeding from not being able to find the bleeding points, tie a handkerchief loosely round the limb above (nearer to the body than) the wound. Put a stick through the loop of the handkerchief and twist it up tight till the bleeding stops. This will make all safe till the arrival of the medical officer. Do not be frightened at a little bleeding, the loss of half a pint of blood will do very little harm to a healthy person, and a very little blood makes a great show.

If the wound is in the chest or belly the less you meddle with it the better. Get the patient stripped, and wait for the medical officer.

Bleeding sometimes occurs from a varicose vein in the leg. No form of bleeding is so easy to stop as this, and yet very many persons have bled to death for want of knowing how to treat this simple affair. Lay the patient on his back on the ground and put his leg up on a chair. No pressure will be necessary; the bleeding will cease of its own accord.

Broken Bones.—When a patient has had a fall, the greatest care must be taken in raising him. Especially in the case of old people and of general paralytics, there must be no attempt made to raise them to their feet until it has been ascertained that their legs are not broken. It is not the lower leg below the knee that is in much danger

from simple falls. The fracture, when there is one, is commonly in the thigh, and especially high up in the neck of the thigh bone. Before, therefore, you raise to his feet a feeble old man or a general paralytic who has fallen down, notice whether his legs are lying in natural positions. Notice whether one leg appears shorter than the other ; notice whether either foot is turned outward so as to lie with the whole of its outer edge touching the ground. If this is so, and the patient is lying on his back, you may be sure the hip is broken. Before lifting the patient, take hold of each ankle, and move the leg gently. If the patient complains of pain or flinches, leave him alone till the medical officer arrives. It is impossible to lay too much stress on the importance of not lifting a patient who has a broken leg : and the reason is this :— that there is great danger of changing a simple fracture, which is of comparatively little importance, into a compound fracture, which is dangerous to life. In a simple fracture there is no wound of the skin. In a compound fracture, not only is the bone broken, but the fracture of the bone communicates with the outer air by means of a wound in the skin, and fractures thus complicated are very much more dangerous than those that are simple.

If you have reason to believe that a patient has broken his leg, and if the services of the medical officer are not immediately available, tie the patient's ankles together, then tie the legs together at the knees, and then tie the

feet together so that the balls of the great toes touch each other. Then lift the patient on to a stretcher and carry him to bed. Do not undo the ties until he is in bed.

If there is a fracture between the knee and the ankle, the danger of the broken ends of the bones piercing the skin, and so turning a simple fracture into a compound one, is very much greater than when the thigh is broken. Sometimes a fracture in this position is at once apparent from the distorted shape and position of the limb. In other cases it is extremely difficult to tell whether the bone is broken or no, and yet it may be very dangerous to get the patient on his feet. In every case, therefore, in which a patient complains of pain in the leg or foot after a fall, he should be left lying where he fell until he can be examined by the medical officer. If it is imperatively necessary to move him, as, for instance, if he is lying in a doorway, and in danger of being trampled on by other patients, he must be lifted by the shoulders only and drawn straight backwards just far enough to be out of the way. If the patient is at some distance from his bed, and it becomes necessary to apply splints before removing him thither, this should be done by the medical officer. The application of splints by amateurs is not to be recommended; and where, as in asylums, medical aid is immediately available, it ought never to be done.

A broken arm is more easily recognised as a rule than a broken leg, and is on every account a much less serious

affair. The simplest way to support it and keep it from being aggravated until aid arrives is to make a sling by tying a towel or large handkerchief round the patient's neck, and allowing the forearm to lie in the loop, taking care that the whole of the forearm from the elbow to the knuckles lies in a horizontal position in the sling.

The signs of broken ribs can scarcely be recognised by attendants. It has already been laid down that the attention of the medical officer is always to be called to every patient who has had a fall or a blow, and this warning may be repeated here. In addition, whenever a patient has had a fall, and especially if the patient be aged or a general paralytic, the attendant should be on the look-out to notice the way that patient breathes. If he takes short rapid shallow breaths, and especially if from time to time he "catches" his breath, or if he complains of pain in the side, it is very likely that he has a broken rib. It is quite common for a patient who has several ribs broken to make no complaint of pain—see Cases 12 to 15, 17, and 18—and this symptom cannot be relied on. The chief indication is the manner of breathing.

Scalds and Burns.—The less these are meddled with before the medical officer sees them the better. Nothing should be done except to remove the clothing, cutting it wherever it sticks to his skin, and leaving the portions sticking on. The blisters should not be opened.

Hanging.—It seems unnecessary to say that a patient

who is discovered hanging should be at once cut down, but cases have occurred in which an attendant, instead of taking this obvious step, has run away screaming. The patient does not derive much benefit from this course of action. He should at once be cut down, and not only this but the cord around his neck must be loosened. It sometimes happens that even after the part of the cord by which he hangs is severed, the portion round the neck remains tight.

Strangulation.—Cut the cord and send for the doctor.

Drowning.—As soon as the patient is removed from the water clear his nose and mouth of any mud or other mess, lay him on his stomach with his face downward and put one of his arms under his forehead, open his mouth and pull his tongue out. This will let the water run out of his mouth and nose.

See if he breathes. If not, turn him on his back, and do his breathing for him in the following way:—Kneel behind his head, put his elbows by his sides and bend them so that the hands lie on the shoulders. Take an arm in each hand, grasping the forearm close to the elbow. Pull the arms straight back so that they stretch on each side of his head, your hands being behind your knees. Count five. Put the arms back into the first position, the elbows being rather to the front of the chest; lean over, and press them hard into the chest. Count three. Repeat.

Watch the patient's face—if it flushes you may know

that your efforts are successful, and that the patient is beginning to breathe naturally. He must still be helped for a while—say five or ten minutes.

Artificial breathing must be kept up for at least two hours before hope is abandoned.

As soon as artificial breathing is begun, but not before, the patient must be wrapped in hot blankets. When he begins to breathe naturally wrap him up very warm and put hot bottles to his legs and sides, taking care that there is a blanket between the bottle and the skin, or he may be badly burnt.

To Carry an Injured or Helpless Patient.—There are several ways of doing this:—

1. If the patient can sit up and is well able to help himself, as, for instance, in the case of a sprained ankle: two attendants, each grasps his own right wrist with his left hand. Then each grasps with his right hand the left wrist of the other. On the platform thus formed the patient sits, and puts his arms round the necks of the attendants.

2. If the patient is more helpless than this — say recovering from a faint: two attendants stand one on each side of him. Each attendant puts one arm under the thighs of the patient close up to the buttocks, and grasps the hand, or better, the coat sleeve of the other. Each attendant puts his other arm round the patient's waist and grasps the other attendant's arm. The patient puts

his arms round the necks of his bearers or grasps their shoulders. Instead of being round the patient's waist the second pair of arms may be behind his shoulders, if he can sit up.

3. If the patient is quite helpless—as for instance, if he is unconscious—one attendant stands at the head of the patient, who is lying, we suppose, on his back, the other stands between the patient's knees, with his back towards the first attendant, and his face towards the patient's feet. The first attendant raises the patient's shoulders, and places his own arms from behind right up to the elbows under the patient's armpits, and hooks the fingers of one hand into the fingers of the other in front of the patient's chest. The second attendant takes the patient's legs just above the knees under his own arms, passes his forearms under the patient's knees, and hooks the fingers of one hand into the fingers of the other in front of his own stomach. The patient is, of course, carried feet foremost.

4. If a stretcher is available, lay the stretcher on the ground, not by the side of the patient, but at his head and in a line with him, the foot of the stretcher being towards the patient's head. Two attendants now clasp each other's hands under the patient, as in 2, and lift him backwards on to the stretcher. In carrying the stretcher, hold it at the full length of the arms, not at the shoulders. Take short steps, and **do not keep step**.

CHAPTER V.

CARE OF THE CLEANLINESS OF THE PATIENTS.

Patients in an asylum require very much the same kind of care that is required by children. Some, like elder children, may be trusted to do many things for themselves; others, like younger children, must have everything done for them; but all require careful inspection as to their personal cleanliness. Most require continual reminding and interference, and many need to be treated with the same solicitude as infants in arms, in order to preserve them from the evil consequences of their own filthy habits.

The first thing in the morning, when the patients are got out of bed, care should be taken that they wash properly. If not supervised, they will dress first, and then wipe their faces over with a wet towel. Those who cannot, or will not, wash themselves must, of course, have this office performed for them. Patients whose habits are dirty should be bathed every morning, whether they seem to require it or no. Female patients should do their hair

before going into the day-room. The charge attendant should see that every patient is neatly and tidily-dressed, clean, and hair attended to before sitting down to breakfast. The second attendant sees that the stockings are pulled up and gartered, and the boots fastened.

On coming in from the airing courts the patients wash their hands, and tidy their dress and hair for dinner, those who are incapable of helping themselves being again assisted. Before going to bed the dirty patients and those with sweaty hands have their hands and face washed, but the rest of the patients need not wash at night, unless they desire to do so.

Once in every week every patient who is not ill in bed is to have a bath. The rules for bathing are very stringent, and, as already shown, are very important also. They are as follows:—

1. The head attendant is always to be present.
2. The cold water is to be turned on first, and when enough has been drawn it is to be turned off, and the hot turned on.
3. No bath must exceed 100° without medical order.
4. The bath must not be left so long as there is water in it.
5. More than one patient must not be bathed in the same water.
6. Every bath must be tested with the thermometer before the patient is allowed to get into it.

7. When the bathing is finished the waste is to be left open.

The head attendant superintends the bathing and takes the temperature of the water. The charge and second attendants cut the patients' nails and see to their hair. The under attendants do the bathing.

The bathing should be conducted with all possible decency, and it should never be allowed that a crowd of naked patients accumulate. The patients should partially undress in an adjoining apartment, and pass into the bath-room one by one as the bath is made ready. The more sensible may be allowed to bath themselves; the rest must be rapidly brushed over with the flesh-brush, previously well soaped. After this scrubbing the patient should dip into the water to wash the soap off, and get out of the bath, which is immediately emptied. The attendant then takes a large sponge wrung out dry, and runs it rapidly over the patient, taking off all the adhering water, and leaving the skin damp, but scarcely wet. The drying is then completed with a towel, and the patient passes out of the bath-room to have his nails attended to. If the sponge is used in the way described, the patient can be thoroughly dried with one small towel. If the sponge is not used, a small towel will be sopping wet before the patient is dry. Care should be taken that the bodies of patients are thoroughly dried.

The afternoon of bathing days should be devoted to

the cleansing of the hair, and on that day every patient should have his head combed with a small-tooth comb. They should sit round a table, each patient with his towel round his shoulders, on the table a basin, into which the combings are put, until the operation is over, when they are burnt.

The foregoing instructions apply to ordinary patients. Patients who are exceptionally dirty or untidy in their habits need to be attended to with greater assiduity.

Wet and Dirty Patients.—The day attendant, coming on duty in the morning, ought to find every bed dry and every patient clean, the night nurses having done what changing was necessary immediately before going off duty. As soon as he takes over the charge of the patients, the day attendant should see that every wet patient and every dirty patient goes at once to the closet. This practice should be repeated immediately after every meal, when not only the habitually dirty patients, but all those who are demented should be sent as a matter of routine and of course. By this means a habit is established, even in patients who are completely "lost," of exercising the natural functions at definite times in the day; and as this habit becomes established, their faults in this respect become fewer and fewer, until they cease altogether. Another advantage of this regulation is that the patients attend rapidly one after another, and do not get the opportunity of loitering and spending their time

in the closets—time which is frequently occupied in evil practices. After each meal the attendants see that they go, and see that they come away, and thus evil is prevented in several ways.

In addition to these visits, exceptionally dirty patients should be taken four or five times a day. Patients who wet their beds at night should not be allowed anything to drink after tea, and not more than half a pint of liquid at that meal.

Besides the personal cleanliness of the patients, the cleanliness and tidiness of their clothing have to be cared for. Every ward should have a supply of bibs, which should be put at meal times under the chins of such patients as are unclean feeders. Buttons and other fastenings should be attended to, and kept in efficient order, and care should be taken that they are used. Patients must not be allowed to go about with their boots unfastened, nor with their stockings down about their heels. Male patients should have their collars and neckties fastened. Female patients should not be allowed to have their hair hanging over their faces in a mop, nor in elf-locks. It can be kept in place and neatly arranged even in those who are most determined in pulling it down, and this can be done without cutting it short, which should never be done except for medical reasons. When a patient persistently pulls her hair down, and refuses to allow it to remain up when fastened by ordinary

means, it should be plaited and the plaits sewn together daily.

The cleanliness of the patients depends, of course, to a certain extent upon the amount of clean linen that is supplied to them, and this is a matter which is not under the control of the attendants. Every male patient should have two clean shirts every week, and every female patient two clean shifts, or a shift and a night-dress.

Every patient should have one clean towel a week, and flannels for washing the face should be provided in the lavatories.

Male patients should have clean trousers every week; female patients clean petticoats, flannel once a fortnight, and the upper petticoat on the alternate weeks.

The heads of female patients should not be wetted on bath nights, but should be left for another night specially set apart for that purpose, when time can be given to dry them thoroughly and properly. When the heads are washed on bathing nights they are rarely thoroughly dried. The consequence is that the patients are very apt to catch cold, the pillows are spoilt by the damp, and the patient's hair acquires a musty smell which is difficult to get rid of.

The night attendants should take up periodically during the night those patients who are in the habit of wetting their beds. Three times will be enough for the majority of cases. The beds of such patients should be examined

every hour, and when found to be wet the soiled clothes should immediately be taken off and clean dry ones substituted.

The last thing before going off duty the night attendants should examine every patient, and change every one that needs it, leaving every bed dry and clean when the day attendants come on duty.

CHAPTER VI.

CARE OF THE COMFORT AND WELFARE OF THE PATIENTS.

The guiding principle that the attendant should keep constantly in mind in dealing with patients is one that ought to be inscribed in letters of gold in every ward of the asylum, viz.: **The asylum exists for the benefit of the patients.** It is the duty of every official connected with an asylum to study the comfort and welfare of the patients before all things else. For this reason not only are attendants forbidden to strike patients, but they ought not even to use harshness of language nor manner towards them. The lot of an insane patient in a public asylum can under no circumstances be a very happy one. It is the duty of the attendants to see that it is not unnecessarily grievous, but that the patients may be as cheerful and contented as is possible under the circumstances of their lives. There are various ways, very small, and even trivial, in themselves, which yet, when all put together, and in daily and hourly repetition, make a vast difference in the comfort and happiness of the unfortunate

inmates of asylums. On the male side, many of the attendants have had previous experience in the army, and are accustomed to the peremptory word of command of military life. Often, too, they are addressed by the head attendant with the surly abruptness acquired in the service. It is not unnatural, therefore, that they should treat the patients, over whom they are placed in control, in a corresponding manner, and should order them about in a way that is not customary in civil life, and that is not conducive to amicable relations between them and the patients. With ninety-nine people out of a hundred a civil request is much more likely than a peremptory command to be met by a ready compliance; and this is especially the case when, as with patients in lunatic asylums, the person addressed is under no obligation to obey. "If you please" is a phrase which is easily said, costs no trouble, and lowers no man's dignity; and to the person addressed it makes all the difference between a ready and willing compliance and a grudging obedience or, it may be, a defiant refusal. That attendant who is the most civil and pleasant in his mode of addressing the patients will not only have his patients the most cheerful and contented but will get the most work out of them, and have his ward in the best order. The wards of a lunatic asylum should be as clean and as orderly as the decks of a man-of-war; but they are not the place for rigid discipline, and there must be no rough command to

"sit there," or "stay where you are," or "get out of that," or any orders of the kind. The patients must be under some sort of control, or it would not be necessary for them to be in an asylum at all; but this control must be made as little irksome as possible, and every patient must be allowed as much freedom, and as much power to regulate his own life in the way he likes best, as is possible within the narrow limits in which he moves. The rule may be stated thus: **A patient is not to be interfered with so long as he is doing no harm.** It is no credit to an attendant to have his patients all sitting in rows round the walls of the ward, quite quiet, neat, clean, orderly—and wretched. Let them be as neat and clean as can be, and let them be quiet and orderly too, but do not attempt to suppress what little buoyancy they possess, nor make their dull lives duller than they need be. I would rather find my patients playing leap-frog over the chairs and tables than see them sitting idle and silent and miserable. It is important that the wards should be neat and orderly, but it is much more important that the patients should be happy. If, therefore, a patient is industriously employed in tearing up an old newspaper, or pulling to pieces some flowers that he has brought in from his walk, or employing himself in any other way that is innocent in itself, leave him alone to his own devices, even though he may make a little litter in the ward that will have thereafter to be cleared away. It amuses him; it hurts nobody. Let

him be. It is well, of course, that a patient should be employed in useful work, and it is the duty of every attendant to use every possible endeavour to induce his patients to employ themselves usefully; but it is better that they should be employed uselessly than not at all, and again I say that no patient should be interfered with unless he is doing harm.

There are many little ways in which the comfort of patients may be enhanced by an attendant who is thoughtful and considerate, and desires to do to others as he would be done by. When the wind is in the east he will not open the windows that look towards that aspect. When serving the dinners he will bear in mind who likes meat well done and who likes it underdone; who has an indiscriminate appetite, and who is dainty about his food. He will especially notice complaints about food, and see that they are reported at once to the proper quarter. When a complaint is made about food, a sample of the impugned food should be kept for the responsible officer to see, so that he can determine whether the complaint is well founded or no.

Attendants are apt to think that when patients are "lost" — are completely demented — anything is good enough for them, and such patients often come off very badly. They should be as attentively served, and have as good food, as any other patients.

The attendant whose heart is in his work, and who

does his duty as it should be done, will take care that the oldest and most infirm patients have the most comfortable and warmest seats; he will see that a patient who has long occupied some favourite and customary position is not put out of it by a stronger new-comer; he will pay attention to the complaints of his patients, will remedy the trifling ones himself, and call the attention of his superiors to those that are more grave.

He will always be ready to make peace between the quarrelsome, to cheer the unhappy, and to soothe the excited. He will be ready to start a game, and, when it is started, to yield his place in it to a patient, and go on to some other duty.

He will see that the newspapers are not monopolised by one or two patients, but are distributed among them all. He will take care that the papers are kept out of the hands of destructive patients until they are out of date and done with.

When the patients are engaged in sedentary occupations the attendant should read to them, and in all things he should act towards them with courtesy, kindness, sympathy, and tact, and not with overbearing or bullying.

The wards are to be kept at a temperature of from 60° to 65° or even more in winter, and in summer from 55° to 60°.

CHAPTER VII.

TREATMENT OF THE BODILY MALADIES OF THE PATIENTS.

Every asylum attendant who is not already a trained nurse ought to go through a course of instruction in the infirmary before being passed into the general wards; and even to those who have already received a hospital training, a further course in the asylum infirmary would be advisable, for the insane sick are so widely different from the sick who are sane. In many respects the insane sick are like sick children, for they are very usually incapable of describing, or even of drawing attention to, their own symptoms, and they can give us no aid in discovering the nature of their malady. Similarly, we have to conduct their treatment without any assistance from themselves, and for these reasons a nurse to the insane sick has to exercise far more observation and far more discretion than one who attends on sane people.

Every attendant ought to know how to make a bed, but not every attendant does know. The mattress should first be kneaded and shaken, and turned end for end, or turned

over sideways. Then lay the under blanket, or if a mackintosh sheet is required, lay it on the mattress first, and the blanket over it. When the mackintosh is immediately beneath the sheet it gives a chill to the patient on first getting into bed; it should, therefore, never be so used. Over the under blanket lay the under sheet, a piece of which is left long at the head of the bed to roll the bolster in, while round the rest of the bed it is tucked tightly under the mattress, the part tucked in not so as to extend three or four inches under the side of the mattress and there end in a rumpled edge, but tucked completely in as far as it will go, so that it lies flat. This sheet should be strained quite tightly over the mattress, and if it is not long enough to go well under the latter, it must be fastened to it at the sides with safety pins. You will never keep bedsores from forming unless you keep the surface on which the patient lies perfectly free from creases and wrinkles. Now put the bolster at the head of the bed, on the sheet; bring the loose end of the sheet up behind the bolster, tuck it in under the front of the same; then pull the sheet at the two ends of the bolster, and tuck it under the mattress, straining it well so that no creases are left. Now take the upper sheet, lift up the foot of the mattress, and fold under it about eighteen inches of the sheet, put the mattress down, and draw the sheet lightly to the head of the bed, laying the loose end on the bolster. Put the blankets on in the same way, and

tuck the upper sheet in with them on the two sides of the bed, then throw the quilt over without tucking it in. Now turn down blankets and quilt at the head of the bed, so that the folded edge lies on the front of the top of the bolster. Pull the loose end of the top sheet up towards the head of the bed and turn it completely over the other clothes, so that its edge reaches a quarter or half way down the bed. Do **not** fold this end of the sheet in two or three, as is often done for appearance' sake, as by so doing a loose bag of sheet is often left round the patient's shoulders, and is very uncomfortable.

A draw sheet is a narrow sheet placed across the bed over the under sheet, and reaching only from the patient's waist to his knees. It should be of more than one thickness, and is usually made by folding an ordinary sheet to the right size. The draw sheet should be long enough to leave a good margin hanging down on each side of the bed. When a patient has been lying long in one place it is a great relief to him to have the draw sheet pulled for a foot or more to one side of the bed, so as to substitute a fresh and cool portion of the sheet for the part that he has been lying on. When the draw sheet becomes soiled it should be removed in the manner described below, and a new sheet substituted. Some lazy nurses have a habit of merely drawing from under the patient the soiled portion, rolling it up at the side of the bed, and leaving it there to stink, the patient lying on a clean portion of

the sheet indeed, but having this unsavoury bedfellow. Such a practice is quite inadmissible. A soiled sheet, whether a draw sheet or an ordinary one, should be at once removed.

When it becomes necessary to change the under sheet without raising the patient from bed, he should have his legs stretched straight out, and be rolled or lifted as close to the edge of the bed as possible. Then the sheet should be rolled lengthways from the other side of the bed, and made into a compact roll as close to the patient's side as possible. The clean sheet is then tucked in on the side from which the soiled one has been removed, is spread on the bed, and has the spare portion, which is to go where the patient is now lying, folded lengthways, in the same way as the other, close up to the patient. The patient is then lifted or rolled over the two rolls on to the clean sheet; the soiled one is taken away, and the folded portion of the clean one is pulled out and tucked under the mattress.

A bedsore is a discredit to an attendant, and ought never to be allowed in an asylum patient. By the strict observance of the following rules bedsores can be prevented in all cases except those of broken back, which are not often seen in asylums. 1. The bedclothes on which the patient lies must be kept perfectly smooth, tightly stretched, and free from crumbs. 2. Wet and soiled bedclothes must be removed immediately. 3. The patient

must not be allowed to lie long in one position. If he is paralysed or too feeble to turn himself in bed, he should be turned from side to back and from back to the other side about every two hours. Every morning, and also whenever he is changed in consequence of being wet or dirty, his hips and buttocks must be washed with soap and water, **thoroughly dried,** moistened with spirit lotion, and well powdered.

Everything the patient passes, and all soiled clothes, must, of course, be removed from the room immediately. Anything that is unusual or noteworthy must be kept for the medical officer's inspection.

Every attendant should know how to take a patient's temperature. To do this the index of the thermometer is first shaken down below the arrowhead. The bulb of the instrument is then placed under the patient's tongue or in the armpit. Among the insane the former method cannot often be followed, for obvious reasons. The bulb of the thermometer is placed high up in the armpit, taking care that it touches the skin only, the other end projecting forward. The patient then closes his arm tight against his side, and should hold the elbow with the other hand. Unruly and demented patients must, of course, have the arm held. In three or four minutes the thermometer should be removed, and the upper end of the index, the end farthest from the bulb, marks the temperature.

To give an enema the patient must lie on his left side,

with the buttocks **quite** on the edge of the bed and the knees well drawn up. The nozzle of the enema should then be warmed by dipping in hot water, and well greased. The attendant, his left arm resting on the patient's right hip, with his left hand raises the patient's right buttock, and with the right gently insinuates the nozzle of the enema into the bowel, directing it backward, towards himself. The pipe is retained in position by the left hand, and the syringe is worked slowly and gradually with the right. Before introducing the nozzle the syringe should be worked once or twice to expel the air. In giving an enema it is quite unnecessary to expose the patient.

Few attendants know how to make a poultice. The following is the proper way: While the water is being heated, put the linseed before the fire or in the oven to get warm, and get ready a piece of rag four or five inches longer and broader than the poultice is to be. When the water boils, first scald the basin. Throw this water away, and then pour in as much as you think will be required for the poultice. Add the linseed to the water and beat it rapidly with a knife, fork, or spoon till it is thoroughly mixed. It should be not thin enough to run, and not dry enough to crumble. Turn out the pasty mass upon the rag, spread it evenly about half an inch thick, of the size and shape that the poultice is to be, fold over the wide edges of the rag upon the surface of the poultice. Some lay a

piece of muslin over the face of the poultice to keep the linseed from sticking to the skin. Before applying the poultice to the patient lay the back of your hand on it to be sure that it is not too hot. Lay the poultice on the part to which it is to be applied, not pressing it on, but letting it settle down by its own weight. Cover it with several thicknesses of clothing to retain the heat. Demented patients who are incapable of complaining may easily be severely scalded by a poultice that is too hot. The temperature should therefore always be tested by the back of the hand before the poultice is applied. If the poultice has to be tied on, do not do so until it has lain on for a few minutes to get the skin accustomed to the heat of it. A poultice thus made will retain its heat when covered up for from two to three hours. It should then be removed, for it is very unpleasant, as well as harmful, to have a cold, clammy poultice applied to the skin. The part from which the poultice is taken should be dabbed dry with a soft cloth.

If a mustard poultice is ordered, put a tablespoonful of mustard to each half-pint of linseed.

Fomentations.—Fold a piece of flannel to the size of the fomentation required, and let it contain five or six thicknesses. Lay a towel over an empty basin and put the flannel thus folded on the towel. Pour boiling water over the whole of the flannel, and, when it is all wet, fold up the towel with the flannel inside, and twist it up tight

so as to wring all the water thoroughly out of the fomentation, which is then ready to be applied. It should be covered with several thicknesses of clothing, like the poultice.

Cold compresses are simply pads of several thicknesses of flannel wrung out of cold water, placed on the part ordered, and covered or not with waterproof as may be directed.

Hot-water Bottles.—When you apply hot-water bottles to the feet or to any part of patients, never omit to wrap the bottles in at least two thicknesses of blanket before allowing them to be placed close to the patient. Many patients have been very badly burnt by hot-water bottles, and some have been crippled and bedridden for months by the sores produced by the application of a hot bottle.

The rules as to bathing do not apply to the sick. Baths must not be given to the sick without medical order. But they should be frequently washed—not stripped naked and washed all over at once, but a small portion stripped, washed, dried, and covered, and then a further portion in the same way, until the whole body is gone over. The patient may lie on a mackintosh sheet while being washed, but he should not be slopped over with a quantity of water. The smallest quantity that will suffice should be used, the sponge being damp rather than wet.

Medicines must be given punctually, and exactly as they are ordered. The attendant must always himself administer the medicine, and must note any change that occurs in the patient after it has been taken. Suicidal patients will try to save up their draughts and take several at once. Women will ask for castor oil, and put it on their hair instead of swallowing it.

Medicines ordered twice a day are to be given at 10 a.m. and 6 p.m. Three times a day, at 10 a.m., 2 p.m., and 6 p.m. Every four hours, 10 a.m., 2 p.m., 6 p.m., 10 p.m., 2 a.m., and 6 a.m. Patients are not to be waked for medicine if asleep.

In dealing with the patients, the attendant acts under the orders of the medical officer. He is the instrument by which the medical officer's wishes are carried out; he is, as it were, the hand that works, while the medical officer is the head that devises. But the attendant must be not only the medical officer's hand, he must be his eyes also. The knowledge and skill of the doctor are useless unless his orders are faithfully carried out, but unless he is kept instructed as to the patient's progress during his absence, he will not know what orders to give. The attendant should therefore know what things have to be looked for and observed, what it is important for the doctor to know, and for these things he should keep on the watch. In making his observations and reports the attendant should

cultivate accuracy and precision. To say that a patient is "constipated" or "very constipated," or has "diarrhœa" or "bad diarrhœa" or "very bad diarrhœa," is very little use. What the doctor wants to know in cases of constipation is **how many days** since the patient had a motion. In cases of diarrhœa, what the doctor wants to know is **how many times** in a day or an hour the patient goes to stool. The same accuracy should be cultivated in everything. Instead of saying that a patient "has a bad appetite," say "he ate only one slice of bread and butter of such a size at breakfast," "about so many ounces of meat and so many potatoes at dinner;" instead of saying the patient had a good night or a bad night, the number of hours of sleep should be stated, and so forth. What is required in reports is accuracy and precision before everything. The doctor wants to know not only in what respects the patient is wrong, but also exactly how far wrong he has gone.

The **general appearance and facial expression** are the first things to be noted. If a patient is gaining or losing flesh, especially the latter, he should be brought under the notice of the medical officer, and any change of appearance of any kind is important to be noticed. The **colour** of the face sometimes alters; it may become yellow from jaundice, or may assume an earthy or ashen tint, or a waxy appearance, or a transparent

greenish hue, and in either case indicates some bodily illness which it is important that the doctor should be aware of.

A sunken, "peaked" face, with an anxious expression, often means some disease in the abdomen. A rapid **loss of hair** is a matter that should be reported. **Flushing** of the face should be noticed—when in one cheek only it sometimes indicates inflammation of the lungs.

Swelling of the eyelids is sometimes noticeable the first thing in the morning, but goes off in the day-time. It is an important matter for the doctor to know. **Squinting,** if not permanent, but occurring for the first time or from time to time, should be reported. If the **pupil** of one eye is larger than that of the other, it should be recorded.

About the **mouth** the following matters require notice:—Paleness of the **lips,** drawing of the **mouth to one side**—this is especially noticeable when the patient smiles. **Twitching** and **quivering.**

With respect to the skin, every **rash or eruption,** every **sore, bruise, swelling,** or **mark** of any kind should be reported. Opportunity should be taken when patients are being bathed to notice these points. Unusual **dryness** or **sweating,** and especially **sweating at night.**

Swelling of the feet and ankles, especially noticeable in the evening, is to be reported.

Swellings in the groins are most important, since they usually indicate rupture.

The manner in which patients **execute movements** is important, and any defect or peculiarity should be reported. A **shuffling gait** or **dragging of one foot** indicates paralysis. **Staggering, lifting the feet too high, throwing the feet about** in walking, are all important. Peculiarities in gait first become noticeable when the patient is tired. They are often, therefore, present at one time of day and not at another. When the doctor sees the patient there may be nothing noticeable, and yet at other times the attendant may be able to observe a distinct defect. Difficulty in **rising** and **sitting down** may be due to sciatica. Failure of power in the hands is indicated by the patient **dropping things,** and by the difficulty that he finds in **feeding** himself. Fits of **choking** should be reported, even when slight, since they may indicate that the throat is becoming paralysed. **Stuttering, clipping of words,** and **imperfect articulation** show that paralysis is attacking the mouth.

It is most important that a **fit of shivering** should be noticed and reported, and it is very advisable that when a patient has a fit of shivering his temperature should be taken at once.

The state of the **appetite** should of course be noticed, and if a patient declines his food he should be reported.

The state of his **bowels** should also be noticed, whether constipated or loose, and, as previously stated, the observation and report should be full and accurate. Anything unusual in the condition of the motions should, of course, be noticed, as, for instance, if they contain blood, or slime, or worms, or any indigestible substances, such as stones or nails, that the patient may have swallowed. If a patient **vomits** he should be reported at once. If he has been eating some harmful substance, it will appear in the vomit, and notice should therefore be taken of the vomited matter, and if any such substance is discovered the vomit should be kept for the doctor to see. Patients occasionally eat the leaves of the yew and other poisonous plants, and make themselves ill thereby.

If a patient is attacked by **cough,** it should, of course, be reported. The attendant should notice the character of the cough, as choking or noisy, short or prolonged, "tight" or "loose," sufficiently to be able to answer questions on these points. The matter that the patient spits should be received in a separate spit-cup (patients should not be allowed to use the chambers for this purpose), and kept for the doctor to see. If a patient spits blood, great care should be taken to notice whether the blood comes after a fit of **coughing** or after an attack of **vomiting.** It makes a very great difference in the significance of the bleeding, and it is most important

for the doctor to know. If a patient "catches" his breath or complains of pains in the side it should be reported immediately. It may mean a broken rib.

If a patient passes an unusually large or small quantity of **water** it should be noted and reported; also if the urine is very high coloured, or very thick, or, if neither of these, whether it has a smoky tint. When patients are paralysed or ill in bed, it should be noticed whether they pass water regularly, and if more than six hours elapse without their passing water the matter should be reported.

On coming on duty in the morning, the day attendants should notice the condition of the patients, and every one that appears ill, or more feeble than usual, should be kept in bed until the medical officer has been round. Aged people and those who are demented are apt to fall ill without making any complaint, and the following signs of illness should be looked for:—Any unusual weakness may be due to bodily disease. If a patient is much slower in his movements than usual it may indicate illness. If a patient messes his bed or his clothing who has never done so before, it should be reported, as it is often the first sign of a serious illness. If a patient who has not been in the habit of doing so keeps his hand on one part of his body, that part is likely to be the seat of pain, and the medical officer's attention should be called to it. If a patient who has not previously done so gets into a habit of getting out several times in the night to pass water, it

should be reported, as it may indicate disease of the kidneys.

Demented and paralysed patients who are ill in bed require even more care and attention than ordinary sick people. Crusts form round their eyelids, and must be softened with warm water and wiped away. Soap must not be used here, as it will get into the eyes and cause pain. Similarly, reddish brown crusts called "sordes" form on the lips and teeth. These are to be removed from the teeth with a bit of stick with rag round it, moistened with glycerine. In summer, helpless patients are greatly tormented by flies settling on their faces. The face should be covered with a piece of gauze or leno. In winter restless patients will toss the clothes off and lie exposed to the cold. They must be covered up and the clothes be tucked well in.

With regard to **fits,** attendants must notice whether there is any warning of their approach. Sometimes the patient can tell by some peculiar feeling when the fits are coming on; and often an observant attendant is able to foretell from an alteration in the appearance or demeanour of the patient that a fit or a batch of fits is impending. Some patients before their fits become flushed, others pale, others for a day or two are stupid and drowsy, others become noisy, excited, and turbulent. The way that the patient falls in the fit is to be noticed, whether headlong or sideways, whether dangerously or gently, to which side

he turns, whether the patient passes water or motion in the fit, whether he bites his tongue, how long he remains unconscious, whether the fits begin with a cry or quietly, whether he has more than one kind of fit, and what he does when the fit is over, are all matters of importance which should be observed. Night attendants should be on the alert to notice every movement of patients who have quiet fits.

Special care and precautions must be taken in the case of feeble dements and general paralytics. Such patients are often very restless and difficult to keep in bed; they are very helpless, and apt to fall about, and their bones are often so brittle as to break on the application of very trifling forces. It is a good rule that one attendant should never try to change such a patient. Two attendants should always be employed.

Certain operations have occasionally to be conducted in lunatic asylums, and the attendants should know what things will be required, and should have those things in readiness at the time fixed for the operation. For surgical operations the doctor will give special instructions.

When a **hypodermic injection** is to be given; the attendant should have ready a mug of warm water for washing out the syringe.

When a patient is to be **forcibly fed** there will be required:—1. A wooden chair (some doctors prefer one with arms, some without); 2. Five sheets; 3. A pillow;

4. A bottle of salad oil; 5. Two basins of hot water; 6. Soap and towels; 7. *Strapping;* 8. *Tube and funnel;* 9. *Stomach pump;* 10. *The food*, which must be quite liquid. Nos. 7, 8, 9, and 10, which are printed in italics, will probably be supplied by the doctor, and not kept in the ward.

After a patient has been forcibly fed he must be washed and kept from putting his fingers into his throat to make himself vomit.

Passing a Catheter.—1. Oil; 2. Porringer; 3. Basin of warm water; 4. Soap and towels. The catheter will no doubt be brought by the doctor.

Wet Pack.—1. A bed bare to the mattress; on this, 2. One or two blankets; then 3. A mackintosh; and then 4. An old blanket. Besides this will be required—5. More blankets; 6. A sheet; 7. A bucket of cold water. When the patient is taken out of the pack there will be required—8. A bucket of tepid water; 9. A bucket of cold water; 10. Three hot bath-towels.

Chapped Hands and Chilblains.

Patients often suffer severely in winter from chapped hands. This is entirely due to insufficient drying of the hands after they have been wet. Few patients will take the interest or trouble necessary to go on rubbing the hands over one another after they are dried, until they no longer cling together in the least, but slide over each other

easily, though, if this is done, chaps will be prevented. A quicker way is to rub the hands after drying with flour or oatmeal.

Chilblains are very troublesome and difficult to manage, and the worst examples of them are found among feeble patients in lunatic asylums. Patients who suffer from them should wear warm ringwood gloves several sizes too large for them. Other treatment will be ordered by the medical officer.

Profuse Sweating

of the hands and feet is another tiresome complaint common in asylums. The treatment for this again is chiefly medical, all that the attendant can do being to maintain perfect cleanliness and to use powder after washing.

Sleeplessness.

No condition is more common in asylum patients than sleeplessness, and although it has to be dealt with in the main by the medical officers, attendants can often do much for the improvement of patients in this respect. Patients who sit about all day and get no change of scene and no exercise in the fresh air, cannot be expected to sleep at night. Patients who are habitually wakeful should get plenty of exercise in the daytime, being, if necessary, made to walk between two attendants. The quantity and quality of food that they are ordered will

of course depend on the medical officer; but attendants should remember that no one can sleep with an empty stomach, and therefore these patients should be specially attended to at the last meal of the day, and notice taken whether they eat it or no. Much may be done to help sleepless patients by making their beds comfortable, especially by taking care that they have not too many bedclothes and do not get too hot.

The feet of sleepless patients should be felt, and, if cold, should be wrapped in a hot blanket. Noise of all kinds is to be avoided as much as possible. Night attendants should, therefore, wear noiseless slippers, and should be as quiet as possible in all their movements. They must be especially careful to open and close doors noiselessly. They must avoid flashing their lanterns in the faces of sleeping patients. A hot bath at night is often of great service to a patient troubled with sleeplessness.

Death of a Patient.—When a patient dies, close the eyes, and keep them closed until they remain so. Then wash the body all over; put on a clean pair of stockings and a clean shirt or shift, first ripping the garment down the middle of the back for convenience of putting on. Tie up the jaw; place the arms by the sides and the legs straight out; tie the feet together, and put a block at the feet so as to keep the toes from drooping towards the foot of the bed. By doing this you permit the use of a coffin several inches shorter.

CHAPTER VIII.

TREATMENT OF THE MENTAL MALADIES OF THE PATIENTS.

This is the peculiar and essential part of the duty of an attendant, wherein his ability or deficiency is most conspicuously shown. That he should be efficient in the duties already described is important; but still, even if he is perfect in all the duties laid down in the previous chapters, his services are of no value for the main purposes for which he is employed unless he makes himself efficient in the treatment of the mental maladies of his patients also.

Two qualities are essential in every attendant if he is to be of any real use in this respect. These qualities are sympathy and watchfulness. If he have not sympathy for the unfortunate beings placed under his care; if he do not feel in his heart a real pity and concern for their misfortune; if he be not able to regard all their annoying ways, their offensive habits, their aggravating manners, their abuse, their filthiness, their roughness, and their violence, as the vagaries of irresponsible beings, which are no more to be felt as injuries than are the noises and

dust of some busy workshop; if he cannot attain in some degree to that attitude of mind which "hates the sin and loves the sinner"; if he cannot follow afar off in the footsteps of Him who prayed, "Forgive them, for they know not what they do"; if he is thus wanting in sympathy, it matters not how smart, or how industrious, or how clever, or how energetic he may be, he is not fitted for the post of attendant on the insane, and in the chief portion of his duties he will always be a failure.

With sympathy must go watchfulness. The attendant must be capable of giving to the doctor every information that may be needed about every one of his patients. There are many things which it is very important for a doctor to know which an attendant would never think of noticing unless he was warned beforehand to look out for them. It is not enough, therefore, that an attendant should have a habit of watchfulness, although such a habit is very necessary for him. He must also know what are the things that he has to watch for; and this knowledge makes the difference between the skilled and the unskilled attendant.

The whole secret of the attendant's usefulness in the treatment of insanity lies in the careful study of individual cases. If he treats his patients in the gross, making no distinction between one and another, driving them about like cattle, compelling all to move in the same groove, to do the same things in the same way, at the

same time, he has mistaken his vocation, and had better give it up and go and tend sheep. Each patient has to be watched and studied separately, and treated according to the peculiarities that he presents.

While humanity and kindness are the due of every patient, the attendant must treat with especial tenderness those patients who are freshly admitted. Brought without their consent, and it may be much against their will, into a new world, in which strict restraint is placed upon their liberty, and in which they become witnesses of many terrifying sights and sounds, it is of the utmost importance to their recovery if they are curable, or to their improvement if they be not, that the first impression that they receive should be as favourable as possible. They should therefore be kept as far as possible out of the general turmoil of the ward, and have their tastes and inclinations considered as far as possible.

The attendant is to notice any tendency in his patients towards suicide. As a rule, if suicide has been attempted, a second attempt will be of the same kind as the first. A patient who has once tried to hang himself will neglect opportunities of drowning, but will still retain his tendency to hang himself if he have the opportunity. Similarly, a patient who has once tried to cut his throat will let slip opportunities of hanging himself, but he must not on that account be thought to have lost his suicidal tendency. If he can get hold of a sharp instrument he will cut his

throat again. Without making actual attempts, a tendency to suicide may be inferred from the eagerness with which a patient will watch the knives, or the longing looks that he will give towards a pool of water, or to the ground below if on an upper floor. I have known a patient climb up into the tank above a water-closet, with the intention of drowning himself therein. The tank happened to be empty, but the attempt at suicide remained.

An observant attendant will notice that a patient is not always equally suicidal, but that the tendency comes on from time to time, and will often be able to say beforehand when the patient is likely to be unusually bent upon his purpose.

The same is true of violence as of suicides. Patients who have a tendency to violence usually exert their violence in the same way, and are not always equally inclined to violence. One patient will always hit with his fist, another will always kick, and a third will strike with some weapon. Again, one patient will always attack strangers; another will attack only feeble persons who cannot retaliate upon him; a third will have a grudge against women. Some patients are violent at certain times only of the day, as, for instance, after meals. Some patients are violent only at times, and will have long intervals of quietude and peacefulness, with occasional outbreaks of turbulence and violence. Against such

patients it is usually easy to be on one's guard, for they give plenty of warning, and in most cases the signs preceding each outbreak are the same. Thus one patient who is usually quiet will take to singing for a day or two before he becomes violent; another patient will give warning by upsetting his bath in the morning that he is going to be violent during the day; a third will precede his outbreaks of violence by groundless complaints about his food; a fourth will complain that people have been talking to him in the night; and every attendant who is observant and careful will soon learn that many patients who become violent from time to time give warnings of some kind or other when the violence may be expected. Patients who have a tendency to escape must of course be watched with extra vigilance.

Epileptics are often violent, and the violence will usually be associated with the fits. Usually it occurs before the fits, and lets us know that fits are to be expected. Often, however, the violence follows the fit.

There are many things connected with food and feeding which it is necessary for an attendant to notice.

Some patients refuse food either altogether or at intervals; others throw themselves upon their food with wolfish voracity, and gulp it down in large mouthfuls—a practice which frequently results in choking.

Other patients conceal their food; others, again, will not eat except standing, or apart from the rest, or

altogether alone. Such patients must be humoured. It is hard that they should have these peculiar habits, but it is much worse for them to go without food or to be dragooned and forced into conformity with the ways of the rest. A little humouring or coaxing will often bring them round much sooner; and even if it takes a longer time, it leaves the patient far happier and more amenable to subsequent efforts at reform.

Some patients have a habit of eating filth, stones, cinders, string, pins, nails, and other indigestible substances. Attendants should keep sufficient observation of their patients to know of such habits, and should combat them by keeping the patients constantly in motion when out in the grounds, for it is out of doors that such habits are usually indulged in, and if kept constantly on the move the patients have no opportunity to seek for such things. Moreover, if they stop to pick anything up they are instantly noticed.

Patients who altogether refuse their food, or who are paralysed and unable to feed themselves, must be fed. To do this the attendant first cuts up the dinner, if it be a solid meal, and then stands on the right side of the patient, holding both the patient's hands in his own left behind the patient's back. He then administers the food with a spoon, taking care not to be in a hurry, but to give the patient plenty of time between each mouthful to masticate and swallow what he has already received before

giving him more. This little operation should never be performed until a bib has been placed under the patient's chin.

Patients must not be fed whilst lying down. At the Salop Asylum a patient was thus suffocated in 1882.

When a patient is ordered a special diet, the attendant should see that he gets it, and consumes it himself. A feeble and demented patient may have his diet stolen and eaten by one who is stronger than himself; and it is not infrequent for those who have been ordered extra diets to exchange them away with other patients for tobacco, &c.

Bad habits of all kinds have to be combated and corrected as far as possible. The chief of such habits are as follows:—

Undressing.—Some patients are most difficult to keep decent from their habit of undressing themselves at all hours and in all places. It is usual for such patients to wear clothing with locks instead of buttons, so that it is impossible for them to get the fastenings undone; and this remedy is usually effectual, but it is open to the great objection of rendering the appearance of the patient exceptional and unusual. Everything should be done to avoid such an appearance; and the most successful attendant is he whose patients most resemble sane people in appearance and conduct. Every exceptional appliance, everything that calls attention to the fact that the patients are insane, everything that makes a conspicu-

ous difference between the patients in the asylum and the people outside of it, is to be as far as possible avoided. For this reason locked clothing, and exceptionally strong clothing, and unusual clothing of any kind, is to be used sparingly, and not to be employed until other means have failed. Those patients who have a habit of undressing themselves at inappropriate seasons should therefore have their clothes **sewn** on. The females should have a few stitches put in the band of the skirt, which should fasten behind; and a few more at the neck, the front of the bodice being made double-breasted, so that it cannot be opened below the neck. Male patients should have the waistcoat sewn at the top button, and again at the fourth.

Some patients have a habit of **twisting the buttons off** their clothing. This is not, as a rule, done from mischievousness, but simply from the want of some occupation for the hands. Such patients should be induced to employ themselves in some way. Something must be given them to hold in their hands and to fiddle about with. If they will do nothing else they should be given old newspapers or rags to tear up. Their hands should not be left empty. It is important to notice and counteract the beginning of the habit, for when once formed it will be difficult to cure.

Patients who **tear up their clothes** are often actuated by a similar motive. It is done often simply

for want of something else to do. Such patients should be given rags to tear if they cannot be induced to adopt any other mode of employing themselves.

Picking the skin into sores is another common habit, and one that is very difficult to deal with. Patients who do this must have their nails carefully trimmed, and cut as short as is possible without injuring the quick. This must be done every morning, and if regularly attended to will go far to render the habit impossible.

Pulling out the hair is another bad habit, which, however, is less common, and is not usually a perpetual habit. It is resorted to only occasionally. A patient will sometimes remove his whole beard and whiskers in one day, picking them out hair by hair. One way to deal with this is to keep the patient's attention diverted so long as the habit lasts, which is usually only a few days at a time. Or the patient may be shaved. Female patients who **pull their hair down** must have it sewn up as explained on page 65.

Patients must not be allowed to **sit on the floor.** Female patients especially, when demented, are apt to sit on the floor in a corner of the ward with the skirt of the dress over the head. They are also very apt to sit about in the airing courts on the ground. even in cold and wet weather. In the wards, such patients should be induced to sit on low chairs or settees. In the airing courts they should be made

to walk about. An attendant can give an arm to each of two patients, and two more can link with these, so that one attendant can manage to keep four patients on the move. In this way suicidal patients and those that are apt to sit about can be kept under constant observation. On the male side, patients can more easily be induced to walk about in large parties under the charge of one or two attendants. Of course in this, as in other matters, the attendant must exercise discretion; and the same rule that applies to the cold and wet days of winter need not be adhered to on a broiling day in July.

Many patients have a habit of **hoarding and concealing** things about their persons. This is a matter that need not be interfered with except in certain cases. It is very natural and laudable that every person should like to acquire property, and to keep his acquired property to himself. The trifles that lunatics in asylums are able to acquire may not have much value, but they are of value to their owners simply because they are their own, and this harmless sentiment should not be wantonly interfered with. The attendant, however, if he does not interfere with the habit, should always be aware of it, and should take care to make himself acquainted, by searching the clothes of the patients at night, with the nature of the objects that are thus hoarded and concealed. He should notice whether they consist of: 1. Things that may be used for the purpose of suicide, such as knives, tapes, &c.;

2. Things that may be used as weapons, such as big stones; 3. Food; 4. Rubbish, such as small stones, scraps of paper, leaves, &c.; or 5. Harmless or useful things, such as books, newspapers, ribbons, letters, and so forth. Articles belonging to the first four classes should be removed, but the patients should be allowed to retain things belonging to the fifth.

Nothing is so fertile and certain a source of discontent, of turbulence, noise, and trouble, as insufficient employment, and no patients are so contented, cheerful, and well-conducted as those who are fully employed. The attendants should therefore make every possible endeavour to induce the patients to employ themselves in one way or another. In the male wards this is comparatively easy, for the artisans' shops, the garden, and the farm absorb all the available labour on that side of the house; but in the female wards it is often difficult to find sufficient employment of a suitable character for the patients. The laundry will find occupation for many, and many more may be employed in maintaining the cleanliness of the wards. Others, again, may be occupied in needlework. But when all who are capable of employment in these ways are provided for, there will remain a number of women who will spend their time in idleness unless some special effort is made to find occupation for them, and to induce them to employ themselves therein. Women may be usefully and pleasantly employed in weeding in the

garden, in knitting and netting, crochet, and in other ways, the provision of which belongs more to the duty of the medical superintendent and the matron than to that of the attendants. But whatever the kinds of employment devised and provided, it will be the duty of the attendants to persevere in inducing the patients to follow it industriously. An attendant who is in charge of a working party should remember that the great object is not so much to get the work done, as to get the patients to employ themselves. He should, therefore, not scruple to spend his time in urging and persuading the unwilling patients to work, even though by so doing his own share falls somewhat into arrear. I have several times seen an industrious attendant working away for dear life while many of his patients were standing idle around.

Attendants may be of the greatest service to the doctors by noticing and reporting the character of the delusions that the patients entertain, and of the aberrations of mind that they suffer. The following are the chief things to notice, and although some of them have been mentioned before, no harm will be done by impressing them yet more deeply on the minds of attendants by repetition.

Depression of Spirits.—This is a very common state of mind in patients in asylums, and patients who suffer from it are always a source of anxiety on account of their tendency to suicide. It does not by any means follow,

however, that a patient who appears to be in good spirits will not have a tendency to suicide. Indeed, many attempts at suicide are made by patients who appear to have overcome their depression and to have become cheerful and happy. The signs of depression are easy to recognise. Patients thus affected have a look of unhappiness. They sit about moping and listless, rarely do any work, often sigh and moan, and say, "Oh dear!" or "Oh, my God!" or some such expression. They are very inactive, and dislike exertion. They are also very constipated, and require constant attention in this respect. The delusions that they entertain are all of an unhappy cast. They think they have sinned grievously; that they are eternally lost; that their children, wives, or husbands are dead, or are being ill-treated or tortured; or what not. The attendant should try to find out what it is that such patients have on their minds; often they will not confide in any one until their confidence is gained by kindness and sympathy.

Elevation of spirits is also common among the insane—commoner in men than in women. Patients thus affected are just the reverse of the previous class. They have a happy, jovial expression; often they are busy, continually restless, active and meddling. Their favourite expression is that they are "all right." Often they believe themselves to be immensely wealthy, to be kings, emperors, or God Himself. They have a great idea of their own

powers, and there is nothing that they think they cannot do.

Some patients think that their **bodies are altered** in some way—that they are made of glass, or wood, or some other material, or that their brains have been taken out, or that they have some animal inside them, or that their bowels are stopped, or that they are pregnant, &c.

Religious delusions are very common. Patients with such delusions believe that they have committed the unpardonable sin, or that they are the chosen people of God and cannot go wrong, or that God has inspired them to do this or that.

Sexual delusions and exaggerated **sexual passion** are also common, but do not always go together. Patients with sexual delusions think that people get into their bed and outrage them, or have any of a variety of other delusions connected with the same subject. Patients with excessive sexual passion are very unpleasant persons to have care of. They are always thinking of the one thing, and often indulge in filthy and lascivious gestures and language. They are apt to be very indecent in behaviour, especially before persons of the opposite sex, and need constant watching and checking. The best remedy for such cases is constant and laborious employment.

Delusions of persecution are very important, since they often prompt to acts of violence on the part of those who suffer from them. Such patients believe that some

one, or that several or many people, are constantly trying to injure them. Often they believe that they are persecuted by some mysterious agency, by telephones, or telegraphs, or electricity, or mesmerism.

Delusions of hearing voices are not very uncommon. A patient may be noticed to be talking, as if holding a conversation with some imaginary person, making remarks and asking questions, and apparently listening for the replies, and then going on again.

The above are the chief classes of delusions, but there are many peculiarities of the insane mind which are not included amongst them, and the attendant should be able to give to the doctor an intelligent account of anything in the sayings and doings of the patients which is unusual or which is different from those of sane people.

In making their reports, there is one thing that attendants must be very careful to guard against, and that is. saying more than they know. Never say that a patient **thinks** this, or **imagines** that, or **feels** the other. You cannot be sure of what a patient thinks or imagines or feels. All that you can be sure of is what he **says** and **does,** and your reports should be strictly limited to his sayings and doings.

Except for the purpose of ascertaining them, attendants must not speak to patients about the delusions of the latter. Patients are not to be made a mock of by being addressed by the titles that they fancy are due to them.

nor are they to be teased or twitted with their delusions. The attendant is to take no notice whatever of delusions except to observe and report them.

Note.—Attendants are not to seclude a patient—that is, to shut him in a room by himself—without orders. Neither may they restrain a patient—that is, tie or fasten his limbs or body in any way—without orders.

CHAPTER IX.

THE MAINTENANCE OF CLEANLINESS IN THE WARDS.

It has already been said that the wards of a lunatic asylum should be kept as clean and as orderly as the deck of a man-of-war. Considering, however, the character and habits, as well as the number, of the occupants of the former, this cannot be done except by the most constant assiduity and industry.

In the morning, as soon as the working patients have had their breakfast, they turn to and scrub the floors. There is a right way and a wrong way of scrubbing floors, as of everything else, the chief rule being—and it is especially needed in the case of floors that are washed daily—to use as little water as it is possible to do with. The constant sopping that boarded floors are subjected to in asylums not only causes them to wear out quickly, but contributes more than anything else to the close, foul smell by which many wards are unfortunately distinguished. A zealous attendant in charge of such a ward naturally attributes the smell to some want of cleanliness.

and has the boards washed still more often and sluiced still more copiously with water. The result is that the smell gets worse than ever. In many asylums the floors are now waxed and polished; and this is a very cleanly method, and saves much labour, since much less washing is needed, and when washed the water does not sink in as it does in unpolished wood; but care should be taken that the boards are not too highly polished, or they may become dangerously slippery, as mentioned in a previous chapter.

Before being scrubbed, a floor should be swept, to take off the loose dirt. The scrubber should be furnished with a bucket of warm water, soap, about two square feet of house-flannel, a scrubbing brush, and a mat to kneel on. In some asylums padded boards are used for kneeling on; but they are not safe, as appears from the following case:—

Case 26.—At the Wakefield Asylum two patients were scrubbing side by side, when a quarrel took place: one struck the other with his kneeling board on the head, severely fracturing his skull and lacerating his brain. The patient so struck died very shortly of the blow.

House-flannels should be supplied from the stores, and are often made of the remainder portions of blankets that have been condemned. Attendants should see that the patients do not tear up good blankets into house-flannels, which they are apt to do.

Thus provided, the scrubber first wets a portion of the floor with the house-flannel, then soaps the scrubbing-brush, and scrubs the boards up and down in the direction of their length, not across the grain. The soap is then wiped off the floor with a moderately dry flannel, and is washed out of the flannel into the bucket. Then with a wetter flannel the floor is wiped again, and finally the flannel is wrung out as dry as possible, and the floor wiped hard to get up as much as possible of the moisture. Then a new place is taken and treated in the same manner. The more quickly the water is taken off the floor after it has been put on, the better. Very dirty places that do not yield to mere soap and water should be sprinkled with silver-sand or a mixture of silver-sand and washing-soda in powder, and then scrubbed. Ink stains may be taken out with strong vinegar or oxalic acid. Grease spots should be treated with turpentine, or with oxalic acid, or with benzine, and then washed with soap and soda. None of these substances may be used by patients, for all are more or less poisonous.

In cleaning staircases it is usual to leave small accumulations of dust in the corners of each stair, and when the stairs are scrubbed daily these accumulations of dust become triangular patches of mud. This is especially the case on stone stairs, and gives a very slovenly and neglected appearance to the staircase. Care should be

taken that the corners of the stairs are thoroughly cleaned out.

Oilcloth is rarely used in asylums, and ought never to be. It must not be scrubbed, nor must it be touched with hot water, soap, or soda. It should be cleaned with a flannel and tepid water.

Linoleum is the substance commonly used in asylums as a floor covering. It should never be touched with soda, which is very destructive to it, nor should it be scrubbed with a brush. It may, however, be washed with soap and water, which does not injure it, and may be polished either with milk, a pint to a pail of water, or with a mixture of equal parts of oil and vinegar. It may be polished with cloths, either by hand, or a cloth may be wrapped round a broom so as to cover the bristles, and the linoleum rubbed with that. Great care should be taken in washing floors not to let the water soak under the edge of the linoleum, which soon rots the canvas backing and renders the linoleum useless.

While the patients are scrubbing the floors, the attendants put the table-covers on the tables, from which the breakfast has been cleared away, unpin and shake the curtains, lay down the strips of carpet, and do the dusting.

The walls, when they are of bare or painted brick, should be swept daily.

Every piece of furniture is to be thoroughly dusted,

special attention being paid to the legs of tables, chairs, and settees. The plants on the window sills and all ornaments on mantelpieces and elsewhere are to be moved, and the place on which they stood wiped over with a duster, which should be a little damp, so that the dust is collected by it and not sent flying into the air to settle again. The sashes of the windows are to be similarly rubbed over, together with the panels and tops of the doors. and the tops of bookcases, cupboards, &c. The frames of pictures are to be dusted, especially the tops and backs, and the pictures adjusted so as to hang straight. The blinds are to be pulled straight, and left hanging at the same height throughout the wards. The hot and cold air flues should be kept free from rubbish. When a hot water or steam coil stands in a ward, the patients are apt to push all kinds of rubbish—dirty rags, bits of meat, &c. —through the apertures of the gratings which enclose it. The heat acting on these substances causes them rapidly to putrefy, and thus are produced many stenches which the attendants are at a loss to account for. The gratings enclosing the coils should always be made to open for the purpose of clearing the interior. This is a point of cleanliness which is very rarely attended to, even in asylums otherwise well managed. The valves of the ventilating apparatus should be regulated according to the temperature, and any defect in them should, of course, be at once reported. The door handles. the brasswork of

the fire main, and all other brasswork to be polished, and the wards should be in perfect order and fit for inspection by 10.30 every morning.

After every meal the floors are to be swept, the table-cloths put straight, the hearth swept, and the windows to be thrown open for a longer or shorter time according to the weather and the time of year.

At night, when the patients go to bed, the cloths are to be taken off the tables, shaken, and folded up; and the curtains are to be pinned up, and the strips of carpet shaken, rolled up, and stood on end.

In the course of their duties attendants often get their hands soiled with some substance, such as castor oil or cod-liver oil, the smell of which adheres even after several washings. Crushed linseed made into a paste and rubbed over the hands will sweeten them at once. The same remedy may, of course, be used for patients whose hands have a foul smell. The linseed should be that which is crushed with the oil left in; linseed meal, from which the oil has been extracted, is far less effectual.

In scrubbing the floors, care should be taken to avoid applying soap or soda to the skirtings of the walls, or the paint will be taken off for an inch or two above the floor, and the result will be very unsightly. Paint should not be washed with soap nor with soda, both of which are very destructive to it. The best way to clean paint is with whiting, such as is used for cleaning silver. Wring a

piece of flannel out of warm water, rub it on the whiting, so as to take some up on the flannel, and with this rub the paint. Wash off with plenty of water, and immediately dry with a soft cloth. This method is both quicker and more effectual than cleaning with soap, and does not injure the paint in the least.

The same method is effectual for cleaning brass and bright steel. It is usual to see the paint round door handles and door plates rubbed completely away, and the wood left bare, and highly polished for an inch or two round the brass. This is very unsightly, and should be avoided by holding a piece of cardboard, or better, a piece of zinc, which may always be obtained from the shop, edge to edge with the brass, the edge of the zinc being, of course, cut so as to fit accurately to that of the brass. If brass has got very badly tarnished it may be brightened by applying a little oxalic acid dissolved in water. Steel that is much tarnished must be rubbed with emery and sweet oil. Do not forget the poisonous character of oxalic acid, and take care that no patient is allowed to handle it.

The basins of the water-closets should be cleansed daily by giving them a good flushing with water, at the same time brushing them with a small stiff brush kept for the purpose.

Urinals should be flushed noon and night with *hot* water.

Where hard water is used, the sides of the washhand

basins are apt to get coated with the curdy scum that such waters form with soap. This should be prevented by rinsing after each use. It is not enough to pour the dirty water out of the basin, the latter should be rinsed as well.

Chamber utensils should not be allowed to get furred. This can always be prevented by rinsing and wiping after they are emptied. Should they be found with adhering fur they must be filled with water in which washing-soda has been dissolved and left to stand for a few hours.

The closets, and especially the baths, are not to be used as sinks, nor should slops ever be poured down either of them.

Dormitories do not require scrubbing daily. Once a week is quite enough, especially if the floors are polished. They should, however, be thoroughly swept every day, and the mattresses should be doubled in half and placed at the head of the bed, the bed-clothes folded and laid on the mattress, so that the whole of the floor under the beds lies open to inspection.

Mackintosh sheets that have been wet during the night should be removed and sent out into the open air to sweeten, fresh ones being put in their places. Once a week the under sheet should be taken away and the upper put in its place, a clean upper sheet being provided. Pillow-cases should be changed every week.

Looking-glasses may be cleaned with whiting in the

way recommended for paint, or they may be very well cleaned with newspaper. Half a newspaper is dipped in water and squeezed into a ball, being kneaded until no more water runs out. The glass is cleaned with this, and polished with the other half of the newspaper crumpled up dry into a ball.

The simplest and best way to clean ward furniture is to wash with warm beer and polish with a little paraffin oil. All floor polishes are made of linseed oil, beeswax, turpentine and soap, or of two or more of these ingredients in various proportions. When floors are to be polished they are first scrubbed, and the cracks between the boards are filled, either with putty stained to the same tint that the boards are to have, or better, with pulp made of soaked paper. When dry, the whole floor is painted over with oak staining of the requisite depth of colour, and on the following day is sized. When thoroughly dry, which will not be for a day or two, the floor is painted over with the polish and rubbed with a hand-brush until it shines. Whenever the surface is impaired it can be renewed by rubbing, or a little polish may be added of thinner consistence and containing less wax than the original liquid.

The following may be used for the original polish :— 1. Beeswax 1 lb., turpentine $\frac{1}{2}$ gallon ; cut up the wax and put it in a stone bottle with the turpentine near the fire ; shake frequently ; or, 2. beeswax 1 lb.. turpentine 1 quart, linseed oil (raw) 1 quart ; or. beeswax 1 lb.. tur-

pentine 3 pints, hard soap (Castile) $\frac{1}{4}$ lb.: dissolve the beeswax in the turpentine, cut up the soap and dissolve in $\frac{1}{2}$ pint of water and mix. To renew the polish when required, thin down 1 pint of No. 1 with 1 pint raw linseed oil, 1 pint vinegar, and 1 pint methylated spirit. The same makes an excellent furniture polish. Attendants can maintain the cleanliness of their floors much more easily if those patients who work in the garden and farm take off their heavy working boots before coming into the ward at night, and change them for slippers, or boots of a lighter character.

Vermin.—There are no public institutions without some of these unwelcome visitors, but by steady efforts and persistent cleanliness they may be kept down to a point at which they cease to be a nuisance. Any neglect in this respect is at once followed by a rapid increase in their number, so that no attendant can afford to relax his efforts in this direction.

The most offensive and objectionable vermin, and, unfortunately, the commonest, are bugs. Where wooden bedsteads are used in a public institution the eradication of bugs will be found to be impracticable. The pest may be mitigated, but it cannot be destroyed. The only course is to take the whole of the wooden bedsteads away and burn them. The ward must then be completely cleared out, and all cracks in the floor, between the floor and the skirting, in the skirting itself, between the skirting and

the wall, in the window frames, and between them and the walls, and in the walls also, must be filled with a paste which will harden in the crack without shrinking, and be poisonous to the vermin. Various pastes are used for the purpose, the most effectual containing corrosive sublimate, but as this substance is very poisonous there are objections to its use. Paper pulp made by soaking newspapers in a strong paste containing corrosive sublimate is as good as anything for wide cracks, and for small cracks soft soap and corrosive sublimate. Or chloride of zinc, which is almost equally poisonous, may be substituted for the sublimate. The whole of the floor, walls, and ceiling must then be washed with a ten per cent. solution of Burnett's fluid (chloride of zinc). All bed-clothes must be boiled, and hair mattresses taken to pieces, the ticks boiled, and the hair steamed.

Fleas have a great dislike to certain scents. They usually attack a person from below, by creeping up the legs. A slice of good strong onion rubbed on the stocking just above the ankle, or on the bottom edge of the trousers, will keep them off; or a tape soaked in oil of pennyroyal and tied round the ankle will be a protection. Since fleas live on the person, and do not retreat into cracks in the walls and furniture, they are easily abolished by ordinary attention to cleanliness and the frequent changes of clothing that are insisted on in asylums.

Blackbeetles may be completely exterminated by blow-

ing into the cracks in which they conceal themselves the powder which is sold for that purpose, provided always that the powder is genuine and powerful. Otherwise, they may be trapped in any basin or deep glazed dish by putting a mixture of beer and water therein, sweetened with sugar, and placing sticks for them to climb up.

Crickets may be trapped in the same way. They are thirsty animals.

Attendants are to be careful to check waste of the gas and water. All gas in apartments not actually in use should be turned low. Notice should be taken of water running to waste in closets, urinals, bath-rooms, and lavatories, and the matter should be reported at once.

APPENDIX A.

THINGS THAT AN ATTENDANT MUST NEVER DO.

(*Probationers should read these prohibitions at least once a day for their first year.*)

Never strike a patient.

Never jeer at or tease a patient.

Never let a suicidal patient out of your sight.

Never leave the door of your room unlocked.

Never allow a patient to enter your room.

Never omit to lock up your razor before leaving your room.

Never allow your key to go out of your own possession.

Never lend a patient a knife, a pair of scissors, or an unstruck match.

Never leave broken glass or crockery within reach of patients.

Never omit to search your patients' pockets when they go to bed.

Never allow a patient to put coal on the fire or to sweep the hearth.

Never leave the bath-room while there is water in the bath.

Never turn on the hot water till there is plenty of cold in the bath.

Never put a patient in a bath till you have taken the temperature with a thermometer.

Never leave anything about that may be used by a patient to injure himself or others.

Never fail to report every fall and blow suffered by a patient.

Never go alone to master a violent patient.

Never leave another attendant alone in a ward with violent patients.

Never fall on a patient if you can help it.

Never kneel on any part of a patient.

Never omit to take off the boots of a patient who becomes violent.

Never lock a patient into a single room without orders.

Never polish your floors too highly.

Never let feeble patients go up or down stairs alone.

Never let feeble and vigorous patients crowd through doorways together.

Never lift to his feet a patient who has fallen, till you are satisfied that his leg is not broken.

Never let a general paralytic rise from the table with food in his mouth.

Never hold a patient who is in a fit.

Never let an epileptic patient stand on a chair or table or mount a ladder.

Never omit to notice whether a patient in bed is lying on his face.

Never let a patient lie on a wet sheet.

Never lift up the head of a fainting patient.

Never omit to bathe dirty patients morning and evening as well as on occasion.

Never let wet patients drink as much as they please.

Never order your patients about.

Never interfere with a patient as long as he is doing no positive harm.

Never omit to count your patients when they leave the ward and when they re-enter.

Never make the bath-room a store for brooms, buckets, fuel, clothes, or rubbish, nor use the bath as a sink.

Never fail to report immediately a lock that is out of order.

Never attempt to feed a patient while he is lying down.

Never administer medicine without reading the instructions on the bottle.

APPENDIX B.

LAW RELATING TO ATTENDANTS.

Lunacy Act of 1890.

Section 322.—If any manager, officer, nurse, attendant, or servant, or other person employed in an institution for lunatics . . . ill-treats or wilfully neglects a patient, he shall be guilty of a misdemeanour, and on conviction on indictment shall be liable to fine or imprisonment or to both fine and imprisonment at the discretion of the Court, or be liable on summary conviction for every offence to a penalty not exceeding twenty pounds nor less than two pounds.

This section is very comprehensive. Under it is included not only striking, but every form of ill-treatment; and the neglect may mean not only neglect to properly feed patients and to keep them clean, but any neglect of orders whereby patients can come to harm. For instance:—

Case 27.—In 1880, a patient in Northumberland House was given in charge of the head attendant; with strict

instructions as to careful watching. The attendant, however, left the patient in the garden without placing another attendant in charge of him. The patient committed suicide, and the attendant was prosecuted and fined £15.

Case 28.—At the Somerset Asylum, in 1881, an attendant left a door unlocked, whereby a patient obtained access to a scullery, in which he found means of hanging himself. For his neglect in leaving the door open the attendant was prosecuted and fined £2.

Case 29.—At Rainhill Asylum, in 1883, a patient hanged himself while in charge of an attendant who had orders never to lose sight of him, but who left him unwatched in a dormitory. The attendant was prosecuted for neglect and fined £2.

Other sections of the Act affecting attendants are as follows:—

Section 323.—If any manager, officer, or servant (this, of course, includes attendants) of an institution for lunatics wilfully permits or assists or connives at the escape or attempted escape of a patient, or secretes a patient, he shall for every offence be liable to a penalty not exceeding twenty pounds nor less than two pounds.

Section 324.—If any manager, officer, nurse, attendant, or other person employed in an institution for lunatics . . . . carnally knows or attempts to have carnal knowledge of any female under care or treatment in the insti-

tution. . . . he shall be guilty of a misdemeanour, and, on conviction on indictment, shall be liable to be imprisoned with or without hard labour, for any term not exceeding two years; and no consent or alleged consent of such female thereto shall be any defence to an indictment or prosecution for such offence.

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